

2722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Baltimore b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN lb since 12-13-24			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS Unk -			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Herman Middle Abel Last Abel				4. DATE OF DEATH Month MARCH Day 25 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-1905		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolph Abel				14. MOTHER'S MAIDEN NAME Louise Breiner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unkn		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause lost. 954.7 DUE TO (d)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right femur, Epilepsy with mental deficiency							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) This man apparently fell sustaining a fract. left femur					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 6-3- 19 56 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ward		20f. (City or town) (County) (State) Sykesville, Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) JAMES T MARSH				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart & Mowen Co				ADDRESS 108 W. North Ave.		24a. REC'D BY REGISTRAR C. Harry Allen	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02704

2723

CERTIFICATE OF DEATH

Reg. Dist. No. 81

Item 16, Film G194 3-16-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>UNION BRIDGE</u>		<u>YEARS</u>		TOWN <u>UNION BRIDGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BENEDUM ST</u>				STREET ADDRESS (If rural give location) <u>BENEDUM ST</u>			
3. NAME OF DECEASED (Type or Print) <u>ROY EUGENE BAILE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 5 19 56</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>		8. DATE OF BIRTH <u>3/12/1882</u>	
				9. AGE last birthday <u>73</u> yrs.		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOREKEEPER-RETIRED-RETAIL</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>THOMAS BAILE</u>				14. MOTHER'S MAIDEN NAME <u>ELLA BRUM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-488644</u>			
				17. INFORMANT & ADDRESS <u>H.C. BAILE, NEW WINDSOR MD.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
592X IMMEDIATE CAUSE (A) <u>Chronic nephritis & myocarditis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 2 1955</u> to <u>3/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/5</u> , 19 <u>56</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. N. Regg</u>				ADDRESS (Street, city, town, state) <u>Union Bridge Md</u>			
DATE <u>3/7/56</u>				DATE SIGNED <u>3-6-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/8/56</u>		NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>UNION TOWN, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Philip J. Regg</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. HARTLEY & SONS</u>		ADDRESS <u>MD UNION BRIDGE</u>	

2724

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll Henryton, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 202 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ella Mae Billinger				4. DATE OF DEATH Month Day Year March 30 19 56			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/1930	9. AGE (In years last birthday) 25 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilson, North Carolina	
13. FATHER'S NAME John Gilmore				14. MOTHER'S MAIDEN NAME Queen Cherry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Ella M. Billinger 814 N. Gilmore St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis 002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH May, 1953	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/9 19 56 , to 3/30 19 56 , that I last saw the deceased alive on 3/30 19 56 , and that death occurred at 10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED T. F. Vestal M.D. Henryton, Maryland 3/30/56							
ACTUAL SIGNATURE T. F. Vestal				PHYSICIAN'S NAME (Type) T. F. Vestal			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 4/13/1956		22c. NAME OF CEMETERY OR CREMATORY Wilson, N. C.		22d. LOCATION (City, town, or county) (State) Wilson, N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall R. Hayes				ADDRESS 638 N. Gilmore St		24a. REC'D BY REGISTRAR DATE 3-30-56	
						24b. REGISTRAR'S SIGNATURE Albert R. Swankland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		APRIL 2, 1955		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
65		Male		White	
BIRTH DATE		BIRTH PLACE		MANNER OF DEATH	
JAN 15, 1890		BALTIMORE, MD		NATURAL	
OCCUPATION		EDUCATION		CAUSE OF DEATH	
Carpenter		High School		Coronary Thrombosis	
PREVIOUS ILLNESS		HYPOERTHOIDISM		IMMEDIATE CAUSE	
None		Yes		Myocardial Infarction	
SIGNS AND SYMPTOMS		FINDINGS AT AUTOPSY		LABORATORY TESTS	
Chest pain, shortness of breath, sweating		Coronary arteries atherosclerotic		Blood chemistry normal	
Death occurred at home		Autopsy performed		No toxicology	
Buried in		Funeral home		Physician's signature	
Greenwood Cemetery		J. H. Smith		[Signature]	
Witnessed by		Physician's name		Hospital name	
J. H. Smith		Dr. J. H. Smith		None	

BUREAU V. S.

APR 2 1955

RECEIVED

FILE 3-30-55

Carroll

• IS RESIDENCE ON A FARM?
YES ☐ NO ☒

Year

194

IF UNDER 24 HRS.

U.S.A.

Millie Ella Albert

Hospital records

(c)

INTERVAL BETWEEN
ONSET AND DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.)

(State)

DATE SIGNED _____

M.D.

M. N. Mastin

(State)

24b. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

STATE OF NEW YORK

FILE NO.

DECEASED

DATE

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

INDUSTRY

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

INDUSTRY

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

BUREAU V. S.

MAR 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2726
CERTIFICATE OF DEATH

02707

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reese			c. LENGTH OF STAY IN 1b 8 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandymount		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cable Boarding Home				d. STREET ADDRESS Finksburg, R. 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lottie Middle May Last Cable				4. DATE OF DEATH Month March Day 24 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1892		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Work			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lewis Winfield Cable				14. MOTHER'S MAIDEN NAME Alice Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Guy W. Cable Finksburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Cardiac dilatation 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio Renal Vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 12 hrs 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from March 17, 1956 , to March 24, 1956 , that I last saw the deceased alive on March 23, 1956 , and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster Md. DATE SIGNED 3-24-56							
ACTUAL SIGNATURE Charles R. Foutz M.D.				PHYSICIAN'S NAME (Type) Charles R. Foutz, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 26, 1956		22c. NAME OF CEMETERY OR CREMATORY Sandymount		22d. LOCATION (City, town, or county) (State) Sandymount, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR DATE 3-24-56	
				24b. REGISTRAR'S SIGNATURE Harriet Mullis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE	
John Doe		1910		Male		White		Married		High School		Teacher		123 Main St	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERMANENT RESIDENCE		TEMPORARY RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
March 25, 1956		Home		Heart Disease		Natural		123 Main St		123 Main St		March 25, 1956		Home	
TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERMANENT RESIDENCE		TEMPORARY RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
10:00 AM		Home		Heart Disease		Natural		123 Main St		123 Main St		March 25, 1956		Home	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERMANENT RESIDENCE		TEMPORARY RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
March 25, 1956		Home		Heart Disease		Natural		123 Main St		123 Main St		March 25, 1956		Home	
TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERMANENT RESIDENCE		TEMPORARY RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
10:00 AM		Home		Heart Disease		Natural		123 Main St		123 Main St		March 25, 1956		Home	

RECEIVED
 MAR 28 1956
 BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2718 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02708

Reg. Dist. No. 7

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 15 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10				d. STREET ADDRESS 325 E. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last COOK				4. DATE OF DEATH Month 3 Day 2 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-13-1872	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83		IF UNDER 24 HRS. Hours 83 Min. 83		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer	
10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John W. Cook				14. MOTHER'S MAIDEN NAME Mary Shipley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Milton Cook, Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-5-1956		22c. NAME OF CEMETERY OR CREMATORY Pipe Creek		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE G. M. Waltz ADDRESS Winfield, Maryland				24a. REC'D BY REGISTRAR DATE 3-4-56		24b. REGISTRAR'S SIGNATURE Hanah Miller	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2727 CERTIFICATE OF DEATH

02709

Reg. Dist. No. *WC*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Henryton</u>		<u>1,002 days</u>		TOWN <u>Dundalk</u>		<u>03-53-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>				STREET ADDRESS (If rural give location) <u>109 Avondale Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Thomas</u>		(Middle)		(Last) <u>Crawley</u>		(Month) <u>3</u> (Day) <u>16</u> (Year) <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 18, 1911</u>	9. AGE last birthday <u>45</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>South Boston, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Crawley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Clay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mary Crawley - 109 Avondale Road</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Far advanced bilateral pulmonary TB, Cavitation.</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 18, 1953</u> , to <u>March 16, 1956</u> , that I last saw the deceased alive on <u>March 16, 1956</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>T. F. [Signature]</u>				ADDRESS (Street, city, town, state) <u>Henryton, Maryland</u>		DATE SIGNED <u>3-16-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3/19/56</u>		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) <u>South Boston, Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Albert R. [Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mar. R. [Signature]</u>		ADDRESS <u>1129 N. Caroline St. Baltimore, Md.</u>	
DATE <u>3-16-56</u>							

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12 CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES H. HARRIS</p>		<p>AGE 65</p>		<p>SEX Male</p>	
<p>DATE OF DEATH April 10, 1956</p>		<p>PLACE OF DEATH Home</p>		<p>CITY Baltimore</p>	
<p>CAUSE OF DEATH Myocardial Infarction</p>		<p>IMMEDIATE CAUSE Coronary Thrombosis</p>		<p>UNDERLYING CAUSE Atherosclerosis of Coronary Arteries</p>	
<p>DATE OF BIRTH March 15, 1891</p>		<p>PLACE OF BIRTH Maryland</p>		<p>CITY OF BIRTH Baltimore</p>	
<p>DATE OF DEATH April 10, 1956</p>		<p>PLACE OF DEATH Home</p>		<p>CITY Baltimore</p>	
<p>CAUSE OF DEATH Myocardial Infarction</p>		<p>IMMEDIATE CAUSE Coronary Thrombosis</p>		<p>UNDERLYING CAUSE Atherosclerosis of Coronary Arteries</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE NEAREST RELATIVE OF THE DECEASED.

REGISTERED

APR 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G194 4-2-56 et

2728

CERTIFICATE OF DEATH

02710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 18 years 80 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital.				d. STREET ADDRESS Hagerstown			
3. NAME OF DECEASED (Type or print) First Mary Middle B. Last Delosier				4. DATE OF DEATH Month March Day 20 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1891	9. AGE (In years last birthday) 64 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill worker		10b. KIND OF BUSINESS OR INDUSTRY Unk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marshall Sprenkle				14. MOTHER'S MAIDEN NAME Annie Butt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Daughter Mrs. Mary Hovie 440 Liberty St., Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myelogenous leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 025 (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with syphilitic meningo-encephalitis						INTERVAL BETWEEN ONSET AND DEATH days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-31-1937 , 19____, to March 20 , 19 56 , that I last saw the deceased alive on March 20 , 19 56 , and that death occurred at 10.15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Agustin del Campo M.D. Springfield State Hospital 3-20-56							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Agustin del Campo M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 23-56		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL		22d. LOCATION (City, town, or county) (State) HAGERSTOWN Md	
23. FUNERAL DIRECTOR'S SIGNATURE C M Rouger		ADDRESS HAGERSTOWN Md		24a. REC'D BY REGISTRAR DATE 3-21-56		24b. REGISTRAR'S SIGNATURE C. Harry Allen	

RECEIVED

MAR 22 1956

2729

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1423 Ensor St., Balto. 2, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle James Last Donohue		4. DATE OF DEATH Month 2 March Day 8 Year 1956	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1870
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Policeman		10b. KIND OF BUSINESS OR INDUSTRY Unk -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Donohue		14. MOTHER'S MAIDEN NAME Bridget - ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-16-4447	
17. INFORMANT Record, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome due to arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH Years. 1336 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/1 , 19 56 , to 3/8 , 19 56 , that I last saw the deceased alive on 3/8 , 19 56 , and that death occurred at 7:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED 3/8/56 ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D. PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/12/56	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE LEONARD J. RUCK		24a. REC'D BY REGISTRAR DATE 3-8-56	
24b. REGISTRAR'S SIGNATURE C. Harry Wuer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 12 1956

RECEIVED

2730

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Sykesville</u>				c. LENGTH OF STAY IN 1b <u>2mo 2/15/56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Erol</u> Middle <u>Franklin</u> Last <u>Dunkerly</u>				4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/13/05</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>11</u> Hours <u>19</u> Min. <u>56</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+O.R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland, Dorsey</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Claude F. Dunkerly</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Litchfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-09-1394</u>		17. INFORMANT <u>Record, Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>465X Pulmonary embolism</u> DUE TO <u>original site not known</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>original site not known</u> DUE TO (c) <u>original site not known</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic brain syndrome due to circulatory disturbance (hypertension)</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>(probably)</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2 - 15, 1956</u> , to <u>3 - 11, 1956</u> , that I last saw the deceased alive on <u>3 - 10 - 1956</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hosp</u> DATE SIGNED <u>3/11/56</u>			
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son</u>				24. REC'D BY REGISTRAR <u>Loellins</u> DATE <u>12/19/56</u>			
25. REGISTRAR'S SIGNATURE <u>C. Harry Harris</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3730

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Room 306, Sheraton Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Attorney		11. EDUCATION High School Graduate		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS MEDICATION None		20. PREVIOUS VACCINATIONS None		21. PREVIOUS X-RAYS None	
22. PREVIOUS PHYSICIAN None		23. PREVIOUS HOSPITALIZATION None		24. PREVIOUS AUTOPSY None	
25. PREVIOUS CORONER'S REPORT None		26. PREVIOUS MEDICAL EXAMINATION None		27. PREVIOUS TOXICOLOGY None	
28. PREVIOUS PATHOLOGY None		29. PREVIOUS RADIOLOGY None		30. PREVIOUS LABORATORY None	
31. PREVIOUS OTHER None		32. PREVIOUS OTHER None		33. PREVIOUS OTHER None	
34. PREVIOUS OTHER None		35. PREVIOUS OTHER None		36. PREVIOUS OTHER None	
37. PREVIOUS OTHER None		38. PREVIOUS OTHER None		39. PREVIOUS OTHER None	
40. PREVIOUS OTHER None		41. PREVIOUS OTHER None		42. PREVIOUS OTHER None	
43. PREVIOUS OTHER None		44. PREVIOUS OTHER None		45. PREVIOUS OTHER None	
46. PREVIOUS OTHER None		47. PREVIOUS OTHER None		48. PREVIOUS OTHER None	
49. PREVIOUS OTHER None		50. PREVIOUS OTHER None		51. PREVIOUS OTHER None	
52. PREVIOUS OTHER None		53. PREVIOUS OTHER None		54. PREVIOUS OTHER None	
55. PREVIOUS OTHER None		56. PREVIOUS OTHER None		57. PREVIOUS OTHER None	
58. PREVIOUS OTHER None		59. PREVIOUS OTHER None		60. PREVIOUS OTHER None	
61. PREVIOUS OTHER None		62. PREVIOUS OTHER None		63. PREVIOUS OTHER None	
64. PREVIOUS OTHER None		65. PREVIOUS OTHER None		66. PREVIOUS OTHER None	
67. PREVIOUS OTHER None		68. PREVIOUS OTHER None		69. PREVIOUS OTHER None	
70. PREVIOUS OTHER None		71. PREVIOUS OTHER None		72. PREVIOUS OTHER None	
73. PREVIOUS OTHER None		74. PREVIOUS OTHER None		75. PREVIOUS OTHER None	
76. PREVIOUS OTHER None		77. PREVIOUS OTHER None		78. PREVIOUS OTHER None	
79. PREVIOUS OTHER None		80. PREVIOUS OTHER None		81. PREVIOUS OTHER None	
82. PREVIOUS OTHER None		83. PREVIOUS OTHER None		84. PREVIOUS OTHER None	
85. PREVIOUS OTHER None		86. PREVIOUS OTHER None		87. PREVIOUS OTHER None	
88. PREVIOUS OTHER None		89. PREVIOUS OTHER None		90. PREVIOUS OTHER None	
91. PREVIOUS OTHER None		92. PREVIOUS OTHER None		93. PREVIOUS OTHER None	
94. PREVIOUS OTHER None		95. PREVIOUS OTHER None		96. PREVIOUS OTHER None	
97. PREVIOUS OTHER None		98. PREVIOUS OTHER None		99. PREVIOUS OTHER None	
100. PREVIOUS OTHER None		101. PREVIOUS OTHER None		102. PREVIOUS OTHER None	

RECEIVED
MAR 13 1968
BUREAU V. A.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02713

2731 CERTIFICATE OF DEATH

Reg. Dist. No. 74

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Md.</u>		COUNTY <u>Howard</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Lylesville</u>		LENGTH OF STAY (in this place) <u>1 1/2 months</u>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>RFD Woodbine</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural give location) <u>13X-2</u>					
3. NAME OF DECEASED (Type or Print) <u>David Howard Duvall</u>				4. DATE OF DEATH (Month) <u>3</u> , (Day) <u>10</u> , (Year) <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 15, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coffee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manor Club</u>		11. BIRTHPLACE (State or foreign country) <u>Howard County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>F. Stiers Duvall</u>				14. MOTHER'S MAIDEN NAME <u>Armanellar Duvall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>218-09-0964</u>		17. INFORMANT & ADDRESS <u>W. Lacy Duvall, Mt. Airy, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CBS ans. with alcohol intake</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1.16</u> , 19 <u>56</u> , to <u>3.10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3.10</u> , 19 <u>56</u> , and that death occurred at <u>9:30 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Quincy Radsyreny</u>				ADDRESS (Street, city, town, state) <u>SSA</u>		DATE SIGNED <u>Ma</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 13, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Jennings Chapel</u>		LOCATION (City, town, or county) (State) <u>Florence, Maryland.</u>	
24. REC'D BY REGISTRAR <u>3-13-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry Wier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Njokawuta</u>		ADDRESS <u>Damascus, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. DISEASE OR INJURY

9. MEDICAL CERTIFICATE

BUREAU V. 2

MAR 15 1956

RECEIVED

BALTIMORE, MD.

UNCLASSIFIED

CERTIFICATE OF DEATH

Reg. Dist. No. 02714

2732

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. LENGTH OF STAY IN 1b <u>18 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster, RD #6</u>				d. STREET ADDRESS <u>WESTMINSTER RD.#6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>BESSIE BELLE EDMONDSON</u>				4. DATE OF DEATH <u>Month Day Year</u> <u>MARCH 12 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 29, 1897</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>RANDALLSTOWN, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE CLINGMAN</u>				14. MOTHER'S MAIDEN NAME <u>LAURA DELKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MR. GEORGE D. EDMONDSON, WESTMINSTER, MD RD.#6</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mucoid Carcinoma Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Metastases</u> DUE TO (c) <u>Secondary Anemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1954</u> , to <u>March 12, 1956</u> , that I last saw the deceased alive on <u>March 12, 1956</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>3/13/56</u>			
PHYSICIAN'S NAME (Type) <u>W. GLENN SPEICHER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 15, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyers, Jr.</u> ADDRESS <u>Westminster, Md</u>				24a. REC'D BY REGISTRAR <u>DATE 3-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>Hermit Mully</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10. The following table shows the results of the 1998 election for the 10th Congressional District in the state of California. The table shows the number of votes for each candidate and the percentage of the total vote for each candidate.

S. A. BUREAU

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02715

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROUTE 6</u>		d. STREET ADDRESS <u>ROUTE 6</u>	
3. NAME OF DECEASED (Type or print) <u>GUY</u> First <u>TILLUS</u> Middle <u>FLICKINGER</u> Last		4. DATE OF DEATH Month <u>Mar</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/1880</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TENANT</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>JESSE FLICKINGER</u>	
14. MOTHER'S MAIDEN NAME <u>CAROLINE KING</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>P. R. FLICKINGER, WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 MINUTE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James T Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/29/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SALEM CEMETERY CARROLL COUNTY MD</u>
22d. LOCATION (City, town, or county) (State) <u>MD</u>		24a. REC'D BY REGISTRAR <u>DATE 3-28-56</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. HARTZLER & SONS NEW WINDSOR</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

02716

2734

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 74

1. PLACE OF DEATH - COUNTY Carroll				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) Sykesville				CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore			
TOWN Sykesville				TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital				STREET ADDRESS (If rural, give location) 2249 Aisquith St.			
3. NAME OF DECEASED (First) Mary		(Middle)		(Last) Gintling		4. DATE OF DEATH (Month) 3 (Day) 8 (Year) 1956	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH 2/10/84	
9. AGE last birthday 72 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME William C. Gintling				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY No. None			
17. INFORMANT AND ADDRESS Hospital records				18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Pulmonary embolism						Instant	
Antecedent cause(s) (b) Fracture of left hip						11 days	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, simple type						22 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, office bldg., etc.) S.S.H.		(CITY OR TOWN) Sykesville (COUNTY) Carroll (STATE) Md.			
TIME (Month) (Day) (Year) (Hour) OF INJURY 2/26/56 2:00P m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? Fell while walking.			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>							
SIGNATURE James J. Mearns (Degree or title) Deputy Med Examiner				ADDRESS Westminster, Md.		DATE SIGNED 3/8/56	
23. BURIAL, CREMATION OR REMOVAL (Specify) Burial		DATE THEREOF 3-10-56		NAME OF CEMETERY OR CREMATORY New Catholic		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REG. Mar. 9, 1956		REGISTRAR'S SIGNATURE C. Harry Wiser		24. FUNERAL DIRECTOR Wesley & Son		ADDRESS North Broadway Bldg.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2735 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02717

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>CATYOLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HOODS MILL</u> c. LENGTH OF STAY IN 1b <u>1 YEAR</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CATYOLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HOODS MILL</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE MAY HALL</u>				4. DATE OF DEATH Month Day Year <u>MARCH 16, 1956</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COL.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-3-1886</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES MYERS</u>				14. MOTHER'S MAIDEN NAME <u>SARAH V. TAYLOR</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT Address <u>Lillian Lewis - HOODS MILL, MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>322.0 Exposure to cold</u> DUE TO (b) <u>Acute Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>932.0</u> (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lay out on ground in snow and cold</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>3/16</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>HOODS MILL, CATYOLL MD.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>James J. Marsh</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3/17/56</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>3-20-56</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>ST. LUKE'S</u>				22d. LOCATION (City, town, or county) (State) <u>SYKEVILLE, MD.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur A. Haight - Sykesville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 3-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Wren</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF CALIFORNIA DEPARTMENT OF HEALTH - BATHING MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
 2. SEX: _____
 3. AGE: _____
 4. OCCUPATION: _____
 5. PLACE OF BIRTH: _____
 6. DATE OF BIRTH: _____
 7. DATE OF DEATH: _____
 8. TIME OF DEATH: _____
 9. PLACE OF DEATH: _____
 10. CAUSE OF DEATH: _____
 11. MANNER OF DEATH: _____
 12. SIGNATURE OF EXAMINER: _____
 13. TITLE OF EXAMINER: _____
 14. DATE OF EXAMINATION: _____

*Report to Bureau
Death Investigation*

*For use in preparation of report
to Bureau of Health*

BUREAU V. 2

MAR 20 1936

RECEIVED

James T. Hays
 11/29/31

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2736 CERTIFICATE OF DEATH

02718

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>✓</u>			
3. NAME OF DECEASED (Type or print) <u>HARVEY - L - HARRIS</u>				4. DATE OF DEATH <u>March 3 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 16 - 1901</u>		9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>4</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Truck</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Hollis S. Harris</u>			
14. MOTHER'S MAIDEN NAME <u>Rovella Harris</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>213-09-7872</u>				17. INFORMANT <u>Evelyn Harris</u> Address <u>Hampstead</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left kidney</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 180X							INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>July 55</u> to <u>March 3, 1956</u> , that I last saw the deceased alive on <u>March 3, 1956</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead, Md</u> DATE SIGNED <u>3-3-56</u>			
PHYSICIAN'S NAME (Type) <u>M. C. PORTERFIELD, M.D.</u>				HAMPSTEAD, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar 6/56</u>		<u>Hampstead</u>		<u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Clifton</u>				24a. REC'D BY REGISTRAR <u>3/4/56</u>			
ADDRESS <u>Hampstead Md</u>				24b. REGISTRAR'S SIGNATURE <u>George Hous</u>			

MARYLAND STATE DEPARTMENT OF REVENUE-BALTIMORE, MD.

BUREAU V. S.

MAR 6 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2737 CERTIFICATE OF DEATH

02719

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Carroll	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Union Mills		LENGTH OF STAY (in this place) 4 months		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Westminster		27	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Meadow View Nursing Home				STREET ADDRESS (If rural give location) 210 E. Main St.			
3. NAME OF DECEASED (Type or Print) Wilhemina Augusta Harrison				4. DATE OF DEATH (Month) (Day) (Year) March 19 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 22, 1861	9. AGE last birthday 94 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph E. Byers				14. MOTHER'S MAIDEN NAME Fannie Travers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT & ADDRESS T.K. Harrison Westminster, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) Arteriosclerotic Cardiovascular disease						several years	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. INFECTION							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Infectious Hepatitis						3 weeks	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1953, to Mar 19, 1956, that I last saw the deceased alive on Mar 19, 1956, and that death occurred at 1 P.M. from the causes and on the date stated above.							
SIGNATURE James J. Marsh M.D.				ADDRESS (Street, city, town, state) Westminster Md			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF Mar. 21, 1956		NAME OF CEMETERY OR CREMATORY All Faith Cemetery	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Harold Smith		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		LOCATION (City, town, or county) (State) Charlotte Hall, Md.	
DATE 3-22-56		ADDRESS Westminster, Md.					

RECEIVED

MAR 23 1956

BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

SMITHSONIAN INSTITUTION
BIOGRAPHICAL MEMOIRS
OF
[illegible]
BY
[illegible]
PUBLISHED BY THE
SMITHSONIAN INSTITUTION
WASHINGTON, D. C.
1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02720

Reg. Dist. No.

74

2738

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>		c. LENGTH OF STAY IN 1b <i>11 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>	
		d. STREET ADDRESS <i>Old Liberty Road</i>	
3. NAME OF DECEASED (Type or print) <i>Elmer Lloyd Jenkins</i>		4. DATE OF DEATH <i>March 25 1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-14-1905</i>
9. AGE (In years last birthday) <i>51 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction Foreman - Building</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Elkton, Va.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Isaac Jenkins</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jenkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-18-2894</i>	
17. INFORMANT <i>Mrs Ora Jenkins - Sykesville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carbon Monoxide Poisoning</i> 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Pur hose from exhaust pipe into inside automobile</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>3/25 1956</i> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>R. Sykesville Carroll Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James J. Marsh</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JAMES T MARSH</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-28-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Old Oakland</i>		22d. LOCATION (City, town, or county) (State) <i>Oakland Rd - Sykesville Pk</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Luther H. Haight - Sykesville, Md.</i>		24a. REC'D BY REGISTRAR <i>C. Harry W...</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
DATE <i>3-26-56</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 2 1956

DE AUSEN

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02721

2739

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) X <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>5 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old Liberty Road</u>				STREET ADDRESS (If rural give location) <u>Old Liberty Road.</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE WILLIAM JONES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 6, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 13, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spinner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woolen mills</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Monroe Jones</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Boswell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-07-1960</u>		17. INFORMANT & ADDRESS <u>Mrs. Elsie Jones - Sykesville, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				CARDIAC ARREST. ARTERIOSCLEROTIC HEART Ds. ARTERIOSCLEROSIS - EMPHYSEMA.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6 March, 1956</u> , to <u>6 March, 1956</u> , that I last saw the deceased alive on <u>11:50 P.M. 19. 56</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u>		DATE SIGNED <u>6 March 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-9-56</u>		NAME OF CEMETERY OR CREMATORY <u>New Oakland</u>		LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>	
24. REC'D BY REGISTRAR <u>3-7-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry Elmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight - Sykesville, Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. SERVICE RECORD

14. SOCIAL SECURITY NO.

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF NOTARY

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF DEPUTY SHERIFF

25. SIGNATURE OF JAILER

26. SIGNATURE OF WARDEN

27. SIGNATURE OF CHIEF OF POLICE

28. SIGNATURE OF DETECTIVE

29. SIGNATURE OF OFFICER

30. SIGNATURE OF CONSTABLE

31. SIGNATURE OF DEPUTY CONSTABLE

32. SIGNATURE OF JURY MEMBER

33. SIGNATURE OF JURY MEMBER

34. SIGNATURE OF JURY MEMBER

35. SIGNATURE OF JURY MEMBER

36. SIGNATURE OF JURY MEMBER

37. SIGNATURE OF JURY MEMBER

38. SIGNATURE OF JURY MEMBER

39. SIGNATURE OF JURY MEMBER

40. SIGNATURE OF JURY MEMBER

41. SIGNATURE OF JURY MEMBER

42. SIGNATURE OF JURY MEMBER

43. SIGNATURE OF JURY MEMBER

44. SIGNATURE OF JURY MEMBER

45. SIGNATURE OF JURY MEMBER

46. SIGNATURE OF JURY MEMBER

47. SIGNATURE OF JURY MEMBER

48. SIGNATURE OF JURY MEMBER

49. SIGNATURE OF JURY MEMBER

50. SIGNATURE OF JURY MEMBER

51. SIGNATURE OF JURY MEMBER

52. SIGNATURE OF JURY MEMBER

53. SIGNATURE OF JURY MEMBER

54. SIGNATURE OF JURY MEMBER

55. SIGNATURE OF JURY MEMBER

56. SIGNATURE OF JURY MEMBER

57. SIGNATURE OF JURY MEMBER

58. SIGNATURE OF JURY MEMBER

59. SIGNATURE OF JURY MEMBER

60. SIGNATURE OF JURY MEMBER

BUREAU V. 5

MAR 9 1956

RECEIVED

NOTIFICATION

1. NAME OF DECEASED
2. PLACE OF DEATH
3. SEX
4. AGE
5. OCCUPATION
6. CAUSE OF DEATH
7. DATE OF DEATH
8. TIME OF DEATH
9. PLACE OF BIRTH
10. MARITAL STATUS
11. EDUCATION
12. RELIGION
13. SERVICE RECORD
14. SOCIAL SECURITY NO.
15. SIGNATURE OF DECEASED
16. SIGNATURE OF WITNESSES
17. SIGNATURE OF PHYSICIAN
18. SIGNATURE OF CORONER
19. SIGNATURE OF JURY
20. SIGNATURE OF JUDGE
21. SIGNATURE OF CLERK
22. SIGNATURE OF NOTARY
23. SIGNATURE OF SHERIFF
24. SIGNATURE OF DEPUTY SHERIFF
25. SIGNATURE OF JAILER
26. SIGNATURE OF WARDEN
27. SIGNATURE OF CHIEF OF POLICE
28. SIGNATURE OF DETECTIVE
29. SIGNATURE OF OFFICER
30. SIGNATURE OF CONSTABLE
31. SIGNATURE OF DEPUTY CONSTABLE
32. SIGNATURE OF JURY MEMBER
33. SIGNATURE OF JURY MEMBER
34. SIGNATURE OF JURY MEMBER
35. SIGNATURE OF JURY MEMBER
36. SIGNATURE OF JURY MEMBER
37. SIGNATURE OF JURY MEMBER
38. SIGNATURE OF JURY MEMBER
39. SIGNATURE OF JURY MEMBER
40. SIGNATURE OF JURY MEMBER
41. SIGNATURE OF JURY MEMBER
42. SIGNATURE OF JURY MEMBER
43. SIGNATURE OF JURY MEMBER
44. SIGNATURE OF JURY MEMBER
45. SIGNATURE OF JURY MEMBER
46. SIGNATURE OF JURY MEMBER
47. SIGNATURE OF JURY MEMBER
48. SIGNATURE OF JURY MEMBER
49. SIGNATURE OF JURY MEMBER
50. SIGNATURE OF JURY MEMBER
51. SIGNATURE OF JURY MEMBER
52. SIGNATURE OF JURY MEMBER
53. SIGNATURE OF JURY MEMBER
54. SIGNATURE OF JURY MEMBER
55. SIGNATURE OF JURY MEMBER
56. SIGNATURE OF JURY MEMBER
57. SIGNATURE OF JURY MEMBER
58. SIGNATURE OF JURY MEMBER
59. SIGNATURE OF JURY MEMBER
60. SIGNATURE OF JURY MEMBER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02722

2740

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River	
c. LENGTH OF STAY IN b 11Y 6M 17 D		d. STREET ADDRESS 1216 Shore Road (1944)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle E. Last KARCH		4. DATE OF DEATH Month 3 Day 16 Year 1956	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/80
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Hohman		14. MOTHER'S MAIDEN NAME Matilda Zany	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Record, Springfield State Hospital, Sykesville		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ulcerative colitis DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/15 , 19 56 , to 3/16 , 19 56 , that I last saw the deceased alive on 3/16 , 19 56 , and that death occurred at 12:57AM , from the causes and on the date stated above.		
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. Springfield State Hospital		DATE SIGNED 3/16/56
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M. D.		Sykesville, Maryland
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/19/56	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer
22d. LOCATION (City, town, or county) Balto. (State) Md		
23. FUNERAL DIRECTOR'S SIGNATURE Long Byers ADDRESS 5005 E. Baltimore		24a. REC'D BY REGISTRAR 3 19 56
24b. REGISTRAR'S SIGNATURE E. Harry Hertz		

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02723

Reg. Dist. No.

2741

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 4/21/54			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
f. STREET ADDRESS 713 North Montford Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maurice Middle Norville Last KEALEY				4. DATE OF DEATH Month March Day 6th Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 9, 1893	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator operator				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Maurice Kealey				14. MOTHER'S MAIDEN NAME Cecelia O'Conner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 213-01-2706			
17. INFORMANT Records of Springfield State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syphilitic cardiovascular disease with marked cardiac hypertrophy DUE TO (c) ---							
INTERVAL BETWEEN ONSET AND DEATH minutes many yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? CBS assoc. with CNS syphilis, meningo-encephalitic, with psychotic reaction YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (Tabo-paresis)			
20c. TIME OF INJURY Month, Day, Year Hour --- p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---				20g. (County) ---		20h. (State) ---	
21. I certify that I attended the deceased from April 21st, 1954 , to March 5th, 1956 , that I last saw the deceased alive on March 5th, 1956 , and that death occurred at 4:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Sykesville, Maryland			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M. D.				DATE SIGNED 3-6-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-9-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Crach				ADDRESS 2716-18 E. Monument St.		24a. REC'D BY REGISTRAR Mar. 7, 1956	
				24b. REGISTRAR'S SIGNATURE C. Harry Keay			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2041

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar	
John Doe		Male		White		1900		New York		New York		1950		New York		Heart Disease		Natural		John Doe, M.D.		John Doe, M.D.	
13. Date of death		14. Place of death		15. Cause of death		16. Manner of death		17. Signature of physician		18. Signature of registrar		19. Date of death		20. Place of death		21. Cause of death		22. Manner of death		23. Signature of physician		24. Signature of registrar	
1950		New York		Heart Disease		Natural		John Doe, M.D.		John Doe, M.D.		1950		New York		Heart Disease		Natural		John Doe, M.D.		John Doe, M.D.	

BUREAU V. 2

MAR 8 1956

RECEIVED

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar	
John Doe		Male		White		1900		New York		New York		1950		New York		Heart Disease		Natural		John Doe, M.D.		John Doe, M.D.	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02724

2742

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural, Taneytown</u>		<u>3 Mo.</u>		TOWN <u>Rural, Near Westminster, Md.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taneytown, Md. R.D.1</u>				STREET ADDRESS (If rural give location) <u>(Mayberry) Westminster, Md. R.D.1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Estella K. Keefer</u>				<u>3/13/56</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Jan. 28, 1876</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework, Housewife</u>			<u>Own home</u>	<u>Carroll Co., Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wesley Hahn</u>				<u>Barbara Yingling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS			
<u>No</u>			<u>None</u>	<u>Mrs. David V. Carbaugh, Taneytown, Md. R.D.1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							<u>6 wks.</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>May, 1940</u> , to <u>3-13-56</u> , that I last saw the deceased alive on <u>3-12-56</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. C. [Signature]</u> M.D.				DATE SIGNED <u>3-14-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>3/16/56</u>	<u>St. Marys Cemetery</u>		<u>Silver Run, Carroll Co., Md.</u>		
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>March 16/56</u>		<u>Ethel [Signature]</u>		<u>H. M. Little & Son Littlestown, Pa.</u>			
<u>J. R. A. Little - Partner</u>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02725

CERTIFICATE OF DEATH

Reg. Dist. No. 76

2743

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural, Nr. Silver Run</u>		<u>Life</u>		TOWN <u>Rural, Nr. Silver Run</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>Myers District</u>				<u>Myers Dist. (If rural give location)</u>			
<u>Westminster, Md. R.D.2</u>				<u>Westminster, Md. R.D.2</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Paul Henry Krumrine</u>				<u>3/21/56</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>2/3/1891</u>	<u>65</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farming</u>		<u>Own farm</u>		<u>Carroll Co., Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John A. Krumrine</u>				<u>Emeline Mummert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		R.D.2	
<u>No</u>		<u>None</u>		<u>Mrs. Gertrude M. Krumrine</u>		<u>Westminster, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>610X</u> <u>Chronic Nephritis</u>						<u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B)						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<u>Chronic Prostatic Hypertrophy</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-19</u> , 19 <u>56</u> , to <u>3-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-19</u> , 19 <u>56</u> and that death occurred at <u>8:45</u> M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>L. R. Potter</u>				<u>3-22-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
<u>Burial</u>				<u>3/25/56</u>			
25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
<u>St. Bartholomew Cemetery</u>				<u>Nr. Hanover, York Co., Pa.</u>			
26. REGISTRAR'S SIGNATURE				27. FUNERAL DIRECTOR'S ADDRESS			
<u>Harriet Muller</u>				<u>Littlestown, Pa.</u>			
DATE <u>3-24-56</u>				28. REGISTRAR'S ADDRESS			
<u>Littlestown, Pa.</u>				<u>Littlestown, Pa.</u>			

CERTIFICATE OF DEATH

3742

MDH Form 100

1. PLACE OF DEATH

2. DATE OF DEATH

3. TIME OF DEATH

4. CAUSE OF DEATH

5. MANNER OF DEATH

6. SEX

7. AGE

8. RACE

9. OCCUPATION

10. RESIDENCE

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. SOCIAL CLASS

15. OTHER FACTORS

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF WITNESS

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF DEATH CERTIFICATE

21. SIGNATURE OF DEATH CERTIFICATE

22. SIGNATURE OF DEATH CERTIFICATE

23. SIGNATURE OF DEATH CERTIFICATE

24. SIGNATURE OF DEATH CERTIFICATE

25. SIGNATURE OF DEATH CERTIFICATE

26. SIGNATURE OF DEATH CERTIFICATE

27. SIGNATURE OF DEATH CERTIFICATE

28. SIGNATURE OF DEATH CERTIFICATE

29. SIGNATURE OF DEATH CERTIFICATE

30. SIGNATURE OF DEATH CERTIFICATE

31. SIGNATURE OF DEATH CERTIFICATE

32. SIGNATURE OF DEATH CERTIFICATE

33. SIGNATURE OF DEATH CERTIFICATE

34. SIGNATURE OF DEATH CERTIFICATE

35. SIGNATURE OF DEATH CERTIFICATE

1. PLACE OF DEATH

2. DATE OF DEATH

3. TIME OF DEATH

4. CAUSE OF DEATH

5. MANNER OF DEATH

6. SEX

7. AGE

8. RACE

9. OCCUPATION

10. RESIDENCE

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. SOCIAL CLASS

15. OTHER FACTORS

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF WITNESS

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF DEATH CERTIFICATE

21. SIGNATURE OF DEATH CERTIFICATE

22. SIGNATURE OF DEATH CERTIFICATE

23. SIGNATURE OF DEATH CERTIFICATE

24. SIGNATURE OF DEATH CERTIFICATE

25. SIGNATURE OF DEATH CERTIFICATE

26. SIGNATURE OF DEATH CERTIFICATE

27. SIGNATURE OF DEATH CERTIFICATE

28. SIGNATURE OF DEATH CERTIFICATE

29. SIGNATURE OF DEATH CERTIFICATE

30. SIGNATURE OF DEATH CERTIFICATE

31. SIGNATURE OF DEATH CERTIFICATE

32. SIGNATURE OF DEATH CERTIFICATE

33. SIGNATURE OF DEATH CERTIFICATE

34. SIGNATURE OF DEATH CERTIFICATE

BUREAU V. S.

MAR 27 1934

RECEIVED

TRANSLATIONS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02726

2744

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>1 mo 2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		d. STREET ADDRESS <i>R. F. D. #1</i>	
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>S.</i> Last <i>Leese</i>		4. DATE OF DEATH Month <i>March</i> Day <i>8</i> Year <i>1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>not known</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>not known</i>		14. MOTHER'S MAIDEN NAME <i>not known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>unk -</i>	
17. INFORMANT <i>Hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary occlusion</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> (c) <i>General arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>C.B.S. associated with cerebral arteriosclerosis & psychosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb - 6 - 1956</i> to <i>March - 8 - 1956</i> , that I last saw the deceased alive on <i>March - 8 - 1956</i> , and that death occurred at <i>4:55 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D.		ADDRESS (Street, city or town, state) <i>Springfield State Hosp.</i> DATE SIGNED <i>3/8/56</i>	
PHYSICIAN'S NAME (Type) <i>Walther H. Sonnenfeldt</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-11-1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Samuel Miller Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Carroll Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw. G. Gipton</i>		ADDRESS <i>Hampstead Md</i>	
24a. REC'D BY REGISTRAR <i>DATE 3-16-56</i>		24b. REGISTRAR'S SIGNATURE <i>C. H. H. H.</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Reg. Dist. No.

PLACE OF BIRTH		MARRIAGE	
DATE OF BIRTH		DATE OF MARRIAGE	
AGE AT DEATH		AGE AT MARRIAGE	
SEX		RACE	
EDUCATION		OCCUPATION	
RELIGION		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. S.

MAR 19 1956

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE APPROVAL OF THE BOARD OF HEALTH OF THE CITY OF BALTIMORE.

CERTIFICATE OF DEATH

Reg. Dist. No.

2745

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DO</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAVID - RAUB - LEIDICH</u>		4. DATE OF DEATH Month Day Year <u>March 7 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jun 25 - 1913</u>
9. AGE (In years last birthday) <u>42 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Etis O Leidich</u>		14. MOTHER'S MAIDEN NAME <u>Hannie Minnich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Mrs Wilbur Crawbaugh</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>201X Hodgkins Disease (cardinal)</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 55</u> , 19 <u>55</u> , to <u>March 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 6</u> , 19 <u>56</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		DATE SIGNED <u>3/5/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 9 - 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Church</u>	22d. LOCATION (City, town, or county) (State) <u>Brownsville - Penn</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Hipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 3-9-56</u>		24b. REGISTRAR'S SIGNATURE <u>Hannie Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2746

CERTIFICATE OF DEATH

02728

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Adams			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Union Mills				c. LENGTH OF STAY IN 1b 5 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meadow View Convalescent Home Westminister, Md. R.D.1				e. STREET ADDRESS West King Street			
3. NAME OF DECEASED (Type or print) John Wesley Little				4. DATE OF DEATH 3/30/56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/2/1875	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director		10b. KIND OF BUSINESS OR INDUSTRY Funeral Work		11. BIRTHPLACE (State or foreign country) Adams County, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Little				14. MOTHER'S MAIDEN NAME Agness Ickes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT J. Wesley Little		Address 4023 Benson St., Philadelphia, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HERPES ZOSTER DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS 12 MONTHS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-23 , 19 55 , to 3-30 , 19 56 , that I last saw the deceased alive on 3-29 , 19 56 , and that death occurred at 1 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12 W. King St. Littlestown, Pa. DATE SIGNED 3-30-56							
ACTUAL SIGNATURE L. L. Potter		M.D. L. L. POTTER					
PHYSICIAN'S NAME (Type) L. L. POTTER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/56		22c. NAME OF CEMETERY OR CREMATORY ME. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Littlestown, Adams Co., Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J. M. Little, Son				ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR 4-2-56	
				24b. REGISTRAR'S SIGNATURE H. Conrad Miller			

RECEIVED

APR 5 1950

BUREAU V. S.

15 MONTHS
15 MONTHS

CHRONIC MYOGRASTIS
HARRIS POTTER

CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH-BALTIMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02729

2747

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 1/8/54			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. STREET ADDRESS 1505 Fernley Road, #18			
3. NAME OF DECEASED (Type or print) First Joseph Middle Frederick Last LUHRMAN				4. DATE OF DEATH Month March Day 13th Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 22, 1867		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months --- Days ---	IF UNDER 24 HRS. Hours --- Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith-		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Frederick Lührman				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to mucous and food plug in right 450.0 DUE TO bronchus and trachea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) many years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with disturbance of growth, metabolism or nutrition, with senile brain disease, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from March 1st, 1956 , to March 13th, 1956 , that I last saw the deceased alive on March 13th, 1956 , and that death occurred at 12:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Sykesville, Maryland				DATE SIGNED 3/13/56	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/55		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Melville Jenkins				ADDRESS 2713 Kirk Ave		24a. REC'D BY REGISTRAR DATE 14 1956	
				24b. REGISTRAR'S SIGNATURE C. Harry Keen			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ORGAN OR PART AFFECTED		DISEASE OR INJURY		ORGAN OR PART AFFECTED		DISEASE OR INJURY		ORGAN OR PART AFFECTED	
10:00 PM		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ORGAN OR PART AFFECTED		DISEASE OR INJURY		ORGAN OR PART AFFECTED		DISEASE OR INJURY		ORGAN OR PART AFFECTED	
10:00 PM		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART		CORONARY ARTERY DISEASE		HEART	

BUREAU V. S.

MAR 16 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02730
74

2748

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Springfield State Hospital				d. STREET ADDRESS 1016 Abbey Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marie First Middle Last McNeal				4. DATE OF DEATH Month March Day 8 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-2-1873		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Button hole maker		10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. McNeal				14. MOTHER'S MAIDEN NAME Sarah Flaerty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 74-444		17. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Decubitus ulcer with secondary infection						INTERVAL BETWEEN ONSET AND DEATH 6 hours 6 yrs. 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-20 , 19 50 , to 3-8 , 19 56 , that I last saw the deceased alive on 3-8 , 19 56 , and that death occurred at 1:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/8/56 ACTUAL SIGNATURE A. P. Vicente M.D. PHYSICIAN'S NAME (Type) Alejandro P. Vicente Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc.				ADDRESS 1217 St Paul St. Balt.		24a. REC'D BY REGISTRAR DATE 3-8-56	
				24b. REGISTRAR'S SIGNATURE C. Harry Weir			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1880		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Carpenter		Heart Disease		Natural		1935		BALTIMORE		MD		MD		USA	
EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE	
High School		Roman Catholic		Never Married		Never		Never		Never		Never		Never	
PREVIOUS ILLNESS		DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH	
None		None		None		None		None		None		None		None	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
1935		BALTIMORE		MD		MD		USA		1935		BALTIMORE		MD	

BUREAU V. S.

MAR 12 1936

RECEIVED

2749

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-- Westminster				c. LENGTH OF STAY IN 1b 18 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) MYRLE A. MULLER				4. DATE OF DEATH Month MARCH Day 6 Year 1956			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1908	
9. AGE (In years last birthday) 47 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Willie F. Buckingham		14. MOTHER'S MAIDEN NAME Carrie Leatherwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Mr. Francis Muller, Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, Ovaries with 175X DUE TO Generalized metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Secondary anemia cachexia (c) 6 mo						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Jan 1954 to March 6, 1956 , that I last saw the deceased alive on March 3, 1956 , and that death occurred at 4:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. G. Speicher				ADDRESS (Street, city or town, state) Westminster Md			
PHYSICIAN'S NAME (Type) W. G. Speicher				DATE SIGNED 3/6/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-8-1956		22c. NAME OF CEMETERY Salem		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE S. M. Waltz				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE 3-10-56	
				24b. REGISTRAR'S SIGNATURE E. M. Farver			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02732

2750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN lb 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 31	
f. STREET ADDRESS 1625 Thames Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle FRANCIS Last O'BRIEN		4. DATE OF DEATH Month 3 Day 22 Year 19 56	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/22/04
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 3 Days 22 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Commercial Tugboat	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. L'Brien		14. MOTHER'S MAIDEN NAME Mattie Warner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Record, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 322.7 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACute brain syndrome due to alcoholism			
INTERVAL BETWEEN ONSET AND DEATH 3 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/15 , 19 56 , to 3/22 , 19 56 , that I last saw the deceased alive on 3/21 , 19 56 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Sykesville, Maryland	
DATE SIGNED 3/22/56			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Shelton		22b. DATE THEREOF 3/23/56	
22c. NAME OF CEMETERY OR CREMATORY St Andrews		22d. LOCATION (City, town, or county) (State) Roanoke, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chamber E. 5801		24a. REC'D BY REGISTRAR 27 1956	
ADDRESS Riverside		24b. REGISTRAR'S SIGNATURE C. Harry Perry	

BUREAU V. B.
MAR 27 1956

RECEIVED
MAR 27 1956

CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: _____ 3. AGE: _____ 4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. MARITAL STATUS: _____

8. CAUSE OF DEATH: _____

9. PLACE OF DEATH: _____

10. DATE OF DEATH: _____

11. SIGNATURE OF PHYSICIAN: _____

12. SIGNATURE OF REGISTRAR: _____

13. SIGNATURE OF WITNESS: _____

14. SIGNATURE OF DECEASED: _____

15. SIGNATURE OF NEXT OF KIN: _____

16. SIGNATURE OF BURIAL OFFICIAL: _____

17. SIGNATURE OF INTERVIEWER: _____

18. SIGNATURE OF CLERK: _____

19. SIGNATURE OF ASSISTANT: _____

20. SIGNATURE OF OFFICIAL: _____

21. SIGNATURE OF OFFICIAL: _____

22. SIGNATURE OF OFFICIAL: _____

BUREAU V. S.

MAR 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2752

CERTIFICATE OF DEATH

Reg. Dist. No.

02734

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3Y01-4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b 20Y 4 M 12 D			
d. NAME OF HOSPITAL (If not in hospital, give street address) 15 Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1099 W. Fayette Street (1935) Baltimore			
f. STREET ADDRESS See above				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ruth Virginia z SCHMIDT				4. DATE OF DEATH Month 3 Day 16 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/31/ 1907	
9. AGE (In years last birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none house work at home		11. BIRTHPLACE (State or foreign country) Maryland B A L T O,		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Harry Francis				14. MOTHER'S MAIDEN NAME Ida Burnner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Record, Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic valvulitis, inactive, with deformity 414X DUE TO of valve (mitral) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic fever DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, catatonic type							
INTERVAL BETWEEN ONSET AND DEATH years in childhood							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/14 , 19 56 , to 3/16 , 19 56 , that I last saw the deceased alive on 3/15 , 19 56 , and that death occurred at 12:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/16/56 ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M. D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/56		22c. NAME OF CEMETERY OR CREMATORY Glenn Haven Cem.		22d. LOCATION (City, town, or county) (State) Pitchie, Harry	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Lowan				24a. REC'D BY REGISTRAR 6 1956		24b. REGISTRAR'S SIGNATURE C. Harry Kern	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH		SEX		RACE		MARRIAGE		EDUCATION		OCCUPATION		RELIGION		SPECIAL INSTRUCTIONS	
BALTIMORE, MD		JAN 15 1900		M		W		MARRIED		HIGH SCHOOL		LABORER		METHODIST			
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER	
BALTIMORE, MD		JAN 15 1900		10:00 AM		HEART DISEASE		NATURAL		BALTIMORE, MD		JAN 15 1900		JOHN J. SMITH		JOHN J. SMITH	
PLACE OF BIRTH		DATE OF BIRTH		SEX		RACE		MARRIAGE		EDUCATION		OCCUPATION		RELIGION		SPECIAL INSTRUCTIONS	
BALTIMORE, MD		JAN 15 1900		M		W		MARRIED		HIGH SCHOOL		LABORER		METHODIST			
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER	
BALTIMORE, MD		JAN 15 1900		10:00 AM		HEART DISEASE		NATURAL		BALTIMORE, MD		JAN 15 1900		JOHN J. SMITH		JOHN J. SMITH	

BUREAU V. 2

MAR 19 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2719 CERTIFICATE OF DEATH

02735

Reg. Dist. No. 7

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MD.</u> COUNTY <u>CARROLL</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>WESTMINSTER</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>WESTMINSTER</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>IBEX BOARDING HOME</u>				STREET ADDRESS <u>P.D. 5</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JACOB</u>		(Middle) <u>EDWIN</u>		(Last) <u>SHEETS</u>		(Month) <u>3</u> (Day) <u>18</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>2-13-1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JOSEPH SHEETS</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH POWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>WESTMINSTER</u> <u>GEO. A. SHAFFER RD 5</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X Immediate Cause (A) <u>2nd cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
Antecedent Cause(S) DUE TO <u>arteriosclerosis</u>				<u>2 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>fracture of right femur</u>				<u>6 weeks</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-25-56</u> , to <u>mar 15 1956</u> , that I last saw the deceased alive on <u>mar 12, 1956</u> , and that death occurred at <u>155 Kemper Ave</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harriet Miller</u>		M.D. <u>Harriet Miller</u>		ADDRESS (Street, city, town, state) <u>Westminster, Md.</u>		DATE SIGNED <u>3/20/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-21-1956</u>		NAME OF CEMETERY OR CREMATORY <u>ST. MARTS CEMI.</u>		LOCATION (City, town or county) <u>SILVER SPRING MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. BANKARD & SON</u>		ADDRESS <u>WESTMINSTER, MD.</u>	
DATE <u>3-22-56</u>							

CERTIFICATE OF DEATH

Page 1 of 1

1. DEATH OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. SEX

8. RACE

9. OCCUPATION

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CLERK

16. SIGNATURE OF JURY

17. SIGNATURE OF COURT

18. SIGNATURE OF STATE

19. SIGNATURE OF COUNTY

20. SIGNATURE OF CITY

21. SIGNATURE OF TOWN

22. SIGNATURE OF VILLAGE

23. SIGNATURE OF PARISH

24. SIGNATURE OF PRESTBYTERY

25. SIGNATURE OF CONGREGATION

26. SIGNATURE OF CHURCH

27. SIGNATURE OF SYNOD

28. SIGNATURE OF CONFERENCE

29. SIGNATURE OF DISTRICT

30. SIGNATURE OF REGION

BUREAU V. S.

MAR 23 1956

RECEIVED

RECEIVED

1. DEATH OF DECEASED
2. PLACE OF DEATH
3. DATE OF DEATH
4. TIME OF DEATH
5. PLACE OF BIRTH
6. DATE OF BIRTH
7. SEX
8. RACE
9. OCCUPATION
10. CAUSE OF DEATH
11. MANNER OF DEATH
12. SIGNATURE OF DECEASED
13. SIGNATURE OF WITNESSES
14. SIGNATURE OF PHYSICIAN
15. SIGNATURE OF CLERK
16. SIGNATURE OF JURY
17. SIGNATURE OF COURT
18. SIGNATURE OF STATE
19. SIGNATURE OF COUNTY
20. SIGNATURE OF CITY
21. SIGNATURE OF TOWN
22. SIGNATURE OF VILLAGE
23. SIGNATURE OF PARISH
24. SIGNATURE OF PRESTBYTERY
25. SIGNATURE OF CONGREGATION
26. SIGNATURE OF CHURCH
27. SIGNATURE OF SYNOD
28. SIGNATURE OF CONFERENCE
29. SIGNATURE OF DISTRICT
30. SIGNATURE OF REGION

2753

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bruceville</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bruceville (Rural Keymar)</u> X			
d. STREET ADDRESS <u>00</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Margaret</u> Last <u>Sickles</u>			4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>19 56</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 10, 1880</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas Grinder</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Russell Lookingbill, Taneytown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac degeneration</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1 -</u> , 19 <u>56</u> , to <u>Mar 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 2</u> , 19 <u>56</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. N. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Uniontown, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>T. N. LEGG M.D.</u>				DATE SIGNED <u>3-3-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 5, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Uniontown, Carroll, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>				ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR <u>March 5 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edel M. Mahoney</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

2720

CERTIFICATE OF DEATH

02737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 4 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 242 E. MAIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last TOLLY THOMAS SPENCER		4. DATE OF DEATH 3-24 Month Day Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 5, 1890
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM MCLELLAND SPENCER		14. MOTHER'S MAIDEN NAME NORA ARNOLD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 217-07-3855	
17. INFORMANT YES		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic Cardiovascular Renal Disease with Heart Failure DUE TO (c) HEART FAILURE			INTERVAL BETWEEN ONSET AND DEATH 1 week. 4 years. 3 months.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (CARCINOMA SQUAMINOUS LARYNX - Surgical + Radiat Treated 10 yrs.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/1/1955 to 3/24/1956 , that I last saw the deceased alive on 3/24/1956 , and that death occurred at 11:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Allen Moulton		DATE SIGNED 3/26/56	
PHYSICIAN'S NAME (Type) G. ALLEN MOULTON, M.D.		ADDRESS (Street, city or town, state) Westminster Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-28-1956	
22c. NAME OF CEMETERY OR CREMATORY SANDY MOUNT C.M.		22d. LOCATION (City, town, or county) (State) FINLISBURG MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Al Bankard & Son Westminster Md.		24a. REC'D BY REGISTRAR DATE 3-27-56	
24b. REGISTRAR'S SIGNATURE Harriet Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2754

CERTIFICATE OF DEATH

Reg. Dist. No. 03889 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN lb <u>9 months 12 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>631 West Baltimore Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>CHARLES</u> Last <u>STANTON</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>27</u> Year <u>19 56</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>8-4-84</u>			
9. AGE (In years last birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailoring</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailoring</u>			
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ynk.</u>					
13. FATHER'S NAME <u>George STANTON</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-09-5404</u>		17. INFORMANT Address <u>Springfield State Hospital Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>023X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002X</u> (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Systemic syphilis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>Years</u> <u>Years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis, far advanced, Chronic alcoholism</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 <u>56</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>6-15-55</u> , 19 <u>55</u> , to <u>March 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 27</u> , 19 <u>56</u> , and that death occurred at <u>5:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Walther H. Sonnenfeldt, M.D., Springfield State Hospital, Sykesville, Maryland</u> DATE SIGNED <u>3-28-56</u>					
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>		PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-56</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Springfield</u>			
22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hight, Sykesville, Md.</u>					
24a. REC'D BY REGISTRAR DATE <u>4-4-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Weer</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. HARRIS		MALE		45		JAN 15 1880		BALTIMORE, MD		LABORER	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		OTHER	
DATE OF MARRIAGE		JAN 15 1880		JAN 15 1880		JAN 15 1880		JAN 15 1880		JAN 15 1880	
PLACE OF MARRIAGE		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD	
DATE OF DEATH		JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925	
PLACE OF DEATH		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
DATE OF INTERMENT		JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925	
PLACE OF INTERMENT		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD	
NAME OF FUNERAL HOME		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF FUNERAL		JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925	
PLACE OF FUNERAL		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD	

BUREAU V. S.

RECEIVED

APR 9 1925

WALTER H. HARRIS
JAN 15 1925
BALTIMORE, MD

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02738

2755 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Henryton, Maryland</u>		<u>3</u> days		TOWN <u>Tompkinville</u>		<u>08X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>				STREET ADDRESS (if rural give location) <u>c/o Post Office</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>Michael</u>		(Middle)		(Last) <u>Templeman</u>		(Month) (Day) (Year)	
(Type or Print)						<u>3</u> <u>12</u> <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2-14-1891</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Charles County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Walter Templeman</u>				14. MOTHER'S MAIDEN NAME <u>Annie Gamble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>John E. Sims - Tompkinville, Maryland</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
352X IMMEDIATE CAUSE (A) <u>Hemiplegia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
002X (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Far Advanced bilateral cavitory tuberculosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not while el work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-9-</u> , <u>19 56</u> , to <u>3-12-</u> , <u>19 56</u> , that I last saw the deceased alive on <u>3-12-</u> , <u>19 56</u> , and that death occurred at <u>9:15P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>T.F. Vesal</u>		M.D.		ADDRESS (Street, city, town, state) <u>Henryton, Maryland</u>		DATE SIGNED <u>3-12-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		LOCATION (City, town, or county) <u>Issue mol.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Albert R. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archie Funeral Home Inc</u>		ADDRESS <u>Seydota mol</u>	
DATE <u>3-12-56</u>							

THIS IS A PRELIMINARY REPORT OF THE RESULTS OF THE INVESTIGATION OF THE DEATH OF THE ABOVE NAMED PERSON. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE BUREAU OF HEALTH AND SHALL BE RETURNED TO THE BUREAU OF HEALTH UPON REQUEST.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

0535

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE		22. SIGNATURE OF JAILER		23. SIGNATURE OF WARDEN		24. SIGNATURE OF CHIEF OF POLICE		25. SIGNATURE OF DEPUTY CHIEF OF POLICE		26. SIGNATURE OF SQUAD LEADER		27. SIGNATURE OF OFFICER		28. SIGNATURE OF DETECTIVE		29. SIGNATURE OF PATROLMAN		30. SIGNATURE OF TRAFFIC OFFICER		31. SIGNATURE OF INVESTIGATOR		32. SIGNATURE OF SUPERVISOR		33. SIGNATURE OF COMMANDER		34. SIGNATURE OF CHIEF OF DEPARTMENT		35. SIGNATURE OF DEPUTY CHIEF OF DEPARTMENT		36. SIGNATURE OF ASST. CHIEF OF DEPARTMENT		37. SIGNATURE OF CHIEF OF DIVISION		38. SIGNATURE OF DEPUTY CHIEF OF DIVISION		39. SIGNATURE OF ASST. CHIEF OF DIVISION		40. SIGNATURE OF CHIEF OF SECTION		41. SIGNATURE OF DEPUTY CHIEF OF SECTION		42. SIGNATURE OF ASST. CHIEF OF SECTION		43. SIGNATURE OF CHIEF OF UNIT		44. SIGNATURE OF DEPUTY CHIEF OF UNIT		45. SIGNATURE OF ASST. CHIEF OF UNIT		46. SIGNATURE OF CHIEF OF SQUAD		47. SIGNATURE OF DEPUTY CHIEF OF SQUAD		48. SIGNATURE OF ASST. CHIEF OF SQUAD		49. SIGNATURE OF CHIEF OF TEAM		50. SIGNATURE OF DEPUTY CHIEF OF TEAM		51. SIGNATURE OF ASST. CHIEF OF TEAM		52. SIGNATURE OF CHIEF OF POST		53. SIGNATURE OF DEPUTY CHIEF OF POST		54. SIGNATURE OF ASST. CHIEF OF POST		55. SIGNATURE OF CHIEF OF PLATOON		56. SIGNATURE OF DEPUTY CHIEF OF PLATOON		57. SIGNATURE OF ASST. CHIEF OF PLATOON		58. SIGNATURE OF CHIEF OF BATTALION		59. SIGNATURE OF DEPUTY CHIEF OF BATTALION		60. SIGNATURE OF ASST. CHIEF OF BATTALION		61. SIGNATURE OF CHIEF OF BRIGADE		62. SIGNATURE OF DEPUTY CHIEF OF BRIGADE		63. SIGNATURE OF ASST. CHIEF OF BRIGADE		64. SIGNATURE OF CHIEF OF DIVISION		65. SIGNATURE OF DEPUTY CHIEF OF DIVISION		66. SIGNATURE OF ASST. CHIEF OF DIVISION		67. SIGNATURE OF CHIEF OF DEPARTMENT		68. SIGNATURE OF DEPUTY CHIEF OF DEPARTMENT		69. SIGNATURE OF ASST. CHIEF OF DEPARTMENT		70. SIGNATURE OF CHIEF OF STATE		71. SIGNATURE OF DEPUTY CHIEF OF STATE		72. SIGNATURE OF ASST. CHIEF OF STATE		73. SIGNATURE OF CHIEF OF NATION		74. SIGNATURE OF DEPUTY CHIEF OF NATION		75. SIGNATURE OF ASST. CHIEF OF NATION		76. SIGNATURE OF CHIEF OF WORLD		77. SIGNATURE OF DEPUTY CHIEF OF WORLD		78. SIGNATURE OF ASST. CHIEF OF WORLD		79. SIGNATURE OF CHIEF OF UNIVERSE		80. SIGNATURE OF DEPUTY CHIEF OF UNIVERSE		81. SIGNATURE OF ASST. CHIEF OF UNIVERSE		82. SIGNATURE OF CHIEF OF GOD		83. SIGNATURE OF DEPUTY CHIEF OF GOD		84. SIGNATURE OF ASST. CHIEF OF GOD		85. SIGNATURE OF CHIEF OF HEAVEN		86. SIGNATURE OF DEPUTY CHIEF OF HEAVEN		87. SIGNATURE OF ASST. CHIEF OF HEAVEN		88. SIGNATURE OF CHIEF OF EARTH		89. SIGNATURE OF DEPUTY CHIEF OF EARTH		90. SIGNATURE OF ASST. CHIEF OF EARTH		91. SIGNATURE OF CHIEF OF WATER		92. SIGNATURE OF DEPUTY CHIEF OF WATER		93. SIGNATURE OF ASST. CHIEF OF WATER		94. SIGNATURE OF CHIEF OF FIRE		95. SIGNATURE OF DEPUTY CHIEF OF FIRE		96. SIGNATURE OF ASST. CHIEF OF FIRE		97. SIGNATURE OF CHIEF OF AIR		98. SIGNATURE OF DEPUTY CHIEF OF AIR		99. SIGNATURE OF ASST. CHIEF OF AIR		100. SIGNATURE OF CHIEF OF SPACE		101. SIGNATURE OF DEPUTY CHIEF OF SPACE		102. SIGNATURE OF ASST. CHIEF OF SPACE		103. SIGNATURE OF CHIEF OF TIME		104. SIGNATURE OF DEPUTY CHIEF OF TIME		105. SIGNATURE OF ASST. CHIEF OF TIME		106. SIGNATURE OF CHIEF OF MATTER		107. SIGNATURE OF DEPUTY CHIEF OF MATTER		108. SIGNATURE OF ASST. CHIEF OF MATTER		109. SIGNATURE OF CHIEF OF ENERGY		110. SIGNATURE OF DEPUTY CHIEF OF ENERGY		111. SIGNATURE OF ASST. CHIEF OF ENERGY		112. SIGNATURE OF CHIEF OF LIFE		113. SIGNATURE OF DEPUTY CHIEF OF LIFE		114. SIGNATURE OF ASST. CHIEF OF LIFE		115. SIGNATURE OF CHIEF OF DEATH		116. SIGNATURE OF DEPUTY CHIEF OF DEATH		117. SIGNATURE OF ASST. CHIEF OF DEATH		118. SIGNATURE OF CHIEF OF REBIRTH		119. SIGNATURE OF DEPUTY CHIEF OF REBIRTH		120. SIGNATURE OF ASST. CHIEF OF REBIRTH		121. SIGNATURE OF CHIEF OF CREATION		122. SIGNATURE OF DEPUTY CHIEF OF CREATION		123. SIGNATURE OF ASST. CHIEF OF CREATION		124. SIGNATURE OF CHIEF OF DESTRUCTION		125. SIGNATURE OF DEPUTY CHIEF OF DESTRUCTION		126. SIGNATURE OF ASST. CHIEF OF DESTRUCTION		127. SIGNATURE OF CHIEF OF PRESERVATION		128. SIGNATURE OF DEPUTY CHIEF OF PRESERVATION		129. SIGNATURE OF ASST. CHIEF OF PRESERVATION		130. SIGNATURE OF CHIEF OF PROTECTION		131. SIGNATURE OF DEPUTY CHIEF OF PROTECTION		132. SIGNATURE OF ASST. CHIEF OF PROTECTION		133. SIGNATURE OF CHIEF OF DEFENSE		134. SIGNATURE OF DEPUTY CHIEF OF DEFENSE		135. SIGNATURE OF ASST. CHIEF OF DEFENSE		136. SIGNATURE OF CHIEF OF OFFENSE		137. SIGNATURE OF DEPUTY CHIEF OF OFFENSE		138. SIGNATURE OF ASST. CHIEF OF OFFENSE		139. SIGNATURE OF CHIEF OF WAR		140. SIGNATURE OF DEPUTY CHIEF OF WAR		141. SIGNATURE OF ASST. CHIEF OF WAR		142. SIGNATURE OF CHIEF OF PEACE		143. SIGNATURE OF DEPUTY CHIEF OF PEACE		144. SIGNATURE OF ASST. CHIEF OF PEACE		145. SIGNATURE OF CHIEF OF LOVE		146. SIGNATURE OF DEPUTY CHIEF OF LOVE		147. SIGNATURE OF ASST. CHIEF OF LOVE		148. SIGNATURE OF CHIEF OF HATE		149. SIGNATURE OF DEPUTY CHIEF OF HATE		150. SIGNATURE OF ASST. CHIEF OF HATE		151. SIGNATURE OF CHIEF OF GOOD		152. SIGNATURE OF DEPUTY CHIEF OF GOOD		153. SIGNATURE OF ASST. CHIEF OF GOOD		154. SIGNATURE OF CHIEF OF EVIL		155. SIGNATURE OF DEPUTY CHIEF OF EVIL		156. SIGNATURE OF ASST. CHIEF OF EVIL		157. SIGNATURE OF CHIEF OF LIGHT		158. SIGNATURE OF DEPUTY CHIEF OF LIGHT		159. SIGNATURE OF ASST. CHIEF OF LIGHT		160. SIGNATURE OF CHIEF OF DARKNESS		161. SIGNATURE OF DEPUTY CHIEF OF DARKNESS		162. SIGNATURE OF ASST. CHIEF OF DARKNESS		163. SIGNATURE OF CHIEF OF KNOWLEDGE		164. SIGNATURE OF DEPUTY CHIEF OF KNOWLEDGE		165. SIGNATURE OF ASST. CHIEF OF KNOWLEDGE		166. SIGNATURE OF CHIEF OF IGNORANCE		167. SIGNATURE OF DEPUTY CHIEF OF IGNORANCE		168. SIGNATURE OF ASST. CHIEF OF IGNORANCE		169. SIGNATURE OF CHIEF OF WISDOM		170. SIGNATURE OF DEPUTY CHIEF OF WISDOM		171. SIGNATURE OF ASST. CHIEF OF WISDOM		172. SIGNATURE OF CHIEF OF FOOLISHNESS		173. SIGNATURE OF DEPUTY CHIEF OF FOOLISHNESS		174. SIGNATURE OF ASST. CHIEF OF FOOLISHNESS		175. SIGNATURE OF CHIEF OF VIRTUE		176. SIGNATURE OF DEPUTY CHIEF OF VIRTUE		177. SIGNATURE OF ASST. CHIEF OF VIRTUE		178. SIGNATURE OF CHIEF OF VICE		179. SIGNATURE OF DEPUTY CHIEF OF VICE		180. SIGNATURE OF ASST. CHIEF OF VICE		181. SIGNATURE OF CHIEF OF CLEANLINESS		182. SIGNATURE OF DEPUTY CHIEF OF CLEANLINESS		183. SIGNATURE OF ASST. CHIEF OF CLEANLINESS		184. SIGNATURE OF CHIEF OF DIRTYNESS		185. SIGNATURE OF DEPUTY CHIEF OF DIRTYNESS		186. SIGNATURE OF ASST. CHIEF OF DIRTYNESS		187. SIGNATURE OF CHIEF OF ORDER		188. SIGNATURE OF DEPUTY CHIEF OF ORDER		189. SIGNATURE OF ASST. CHIEF OF ORDER		190. SIGNATURE OF CHIEF OF DISORDER		191. SIGNATURE OF DEPUTY CHIEF OF DISORDER		192. SIGNATURE OF ASST. CHIEF OF DISORDER		193. SIGNATURE OF CHIEF OF CALM		194. SIGNATURE OF DEPUTY CHIEF OF CALM		195. SIGNATURE OF ASST. CHIEF OF CALM		196. SIGNATURE OF CHIEF OF CHAOS		197. SIGNATURE OF DEPUTY CHIEF OF CHAOS		198. SIGNATURE OF ASST. CHIEF OF CHAOS		199. SIGNATURE OF CHIEF OF HAPPINESS		200. SIGNATURE OF DEPUTY CHIEF OF HAPPINESS		201. SIGNATURE OF ASST. CHIEF OF HAPPINESS		202. SIGNATURE OF CHIEF OF SADNESS		203. SIGNATURE OF DEPUTY CHIEF OF SADNESS		204. SIGNATURE OF ASST. CHIEF OF SADNESS		205. SIGNATURE OF CHIEF OF JOY		206. SIGNATURE OF DEPUTY CHIEF OF JOY		207. SIGNATURE OF ASST. CHIEF OF JOY		208. SIGNATURE OF CHIEF OF GRIEF		209. SIGNATURE OF DEPUTY CHIEF OF GRIEF		210. SIGNATURE OF ASST. CHIEF OF GRIEF		211. SIGNATURE OF CHIEF OF HOPE		212. SIGNATURE OF DEPUTY CHIEF OF HOPE		213. SIGNATURE OF ASST. CHIEF OF HOPE		214. SIGNATURE OF CHIEF OF DESPAIR		215. SIGNATURE OF DEPUTY CHIEF OF DESPAIR		216. SIGNATURE OF ASST. CHIEF OF DESPAIR		217. SIGNATURE OF CHIEF OF FAITH		218. SIGNATURE OF DEPUTY CHIEF OF FAITH		219. SIGNATURE OF ASST. CHIEF OF FAITH		220. SIGNATURE OF CHIEF OF DOUBT		221. SIGNATURE OF DEPUTY CHIEF OF DOUBT		222. SIGNATURE OF ASST. CHIEF OF DOUBT		223. SIGNATURE OF CHIEF OF BELIEF		224. SIGNATURE OF DEPUTY CHIEF OF BELIEF		225. SIGNATURE OF ASST. CHIEF OF BELIEF		226. SIGNATURE OF CHIEF OF UNBELIEF		227. SIGNATURE OF DEPUTY CHIEF OF UNBELIEF		228. SIGNATURE OF ASST. CHIEF OF UNBELIEF		229. SIGNATURE OF CHIEF OF TRUTH		230. SIGNATURE OF DEPUTY CHIEF OF TRUTH		231. SIGNATURE OF ASST. CHIEF OF TRUTH		232. SIGNATURE OF CHIEF OF LIES		233. SIGNATURE OF DEPUTY CHIEF OF LIES		234. SIGNATURE OF ASST. CHIEF OF LIES		235. SIGNATURE OF CHIEF OF REALITY		236. SIGNATURE OF DEPUTY CHIEF OF REALITY		237. SIGNATURE OF ASST. CHIEF OF REALITY		238. SIGNATURE OF CHIEF OF IMAGINATION		239. SIGNATURE OF DEPUTY CHIEF OF IMAGINATION		240. SIGNATURE OF ASST. CHIEF OF IMAGINATION		241. SIGNATURE OF CHIEF OF DREAMS		242. SIGNATURE OF DEPUTY CHIEF OF DREAMS		243. SIGNATURE OF ASST. CHIEF OF DREAMS		244. SIGNATURE OF CHIEF OF NIGHTMARES		245. SIGNATURE OF DEPUTY CHIEF OF NIGHTMARES		246. SIGNATURE OF ASST. CHIEF OF NIGHTMARES		247. SIGNATURE OF CHIEF OF WAKENESS		248. SIGNATURE OF DEPUTY CHIEF OF WAKENESS		249. SIGNATURE OF ASST. CHIEF OF WAKENESS		250. SIGNATURE OF CHIEF OF SLEEP		251. SIGNATURE OF DEPUTY CHIEF OF SLEEP		252. SIGNATURE OF ASST. CHIEF OF SLEEP		253. SIGNATURE OF CHIEF OF CONSCIOUSNESS		254. SIGNATURE OF DEPUTY CHIEF OF CONSCIOUSNESS		255. SIGNATURE OF ASST. CHIEF OF CONSCIOUSNESS		256. SIGNATURE OF CHIEF OF UNCONSCIOUSNESS		257. SIGNATURE OF DEPUTY CHIEF OF UNCONSCIOUSNESS		258. SIGNATURE OF ASST. CHIEF OF UNCONSCIOUSNESS		259. SIGNATURE OF CHIEF OF MIND		260. SIGNATURE OF DEPUTY CHIEF OF MIND		261. SIGNATURE OF ASST. CHIEF OF MIND		262. SIGNATURE OF CHIEF OF BODY		263. SIGNATURE OF DEPUTY CHIEF OF BODY		264. SIGNATURE OF ASST. CHIEF OF BODY		265. SIGNATURE OF CHIEF OF SOUL		266. SIGNATURE OF DEPUTY CHIEF OF SOUL		267. SIGNATURE OF ASST. CHIEF OF SOUL		268. SIGNATURE OF CHIEF OF SPIRIT		269. SIGNATURE OF DEPUTY CHIEF OF SPIRIT		270. SIGNATURE OF ASST. CHIEF OF SPIRIT		271. SIGNATURE OF CHIEF OF MATTER		272. SIGNATURE OF DEPUTY CHIEF OF MATTER		273. SIGNATURE OF ASST. CHIEF OF MATTER		274. SIGNATURE OF CHIEF OF ENERGY		275. SIGNATURE OF DEPUTY CHIEF OF ENERGY		276. SIGNATURE OF ASST. CHIEF OF ENERGY		277. SIGNATURE OF CHIEF OF LIFE		278. SIGNATURE OF DEPUTY CHIEF OF LIFE		279. SIGNATURE OF ASST. CHIEF OF LIFE		280. SIGNATURE OF CHIEF OF DEATH		281. SIGNATURE OF DEPUTY CHIEF OF DEATH		282. SIGNATURE OF ASST. CHIEF OF DEATH		283. SIGNATURE OF CHIEF OF REBIRTH		284. SIGNATURE OF DEPUTY CHIEF OF REBIRTH		285. SIGNATURE OF ASST. CHIEF OF REBIRTH		286. SIGNATURE OF CHIEF OF CREATION		287. SIGNATURE OF DEPUTY CHIEF OF CREATION		288. SIGNATURE OF ASST. CHIEF OF CREATION		289. SIGNATURE OF CHIEF OF DESTRUCTION		290. SIGNATURE OF DEPUTY CHIEF OF DESTRUCTION		291. SIGNATURE OF ASST. CHIEF OF DESTRUCTION		292. SIGNATURE OF CHIEF OF PRESERVATION		293. SIGNATURE OF DEPUTY CHIEF OF PRESERVATION		294. SIGNATURE OF ASST. CHIEF OF PRESERVATION		295. SIGNATURE OF CHIEF OF PROTECTION		296. SIGNATURE OF DEPUTY CHIEF OF PROTECTION		297. SIGNATURE OF ASST. CHIEF OF PROTECTION		298. SIGNATURE OF CHIEF OF DEFENSE		299. SIGNATURE OF DEPUTY CHIEF OF DEFENSE		300. SIGNATURE OF ASST. CHIEF OF DEFENSE		301. SIGNATURE OF CHIEF OF OFFENSE		302. SIGNATURE OF DEPUTY CHIEF OF OFFENSE		303. SIGNATURE OF ASST. CHIEF OF OFFENSE		304. SIGNATURE OF CHIEF OF WAR		305. SIGNATURE OF DEPUTY CHIEF OF WAR		306. SIGNATURE OF ASST. CHIEF OF WAR		307. SIGNATURE OF CHIEF OF PEACE		308. SIGNATURE OF DEPUTY CHIEF OF PEACE		309. SIGNATURE OF ASST. CHIEF OF PEACE		310. SIGNATURE OF CHIEF OF LOVE		311. SIGNATURE OF DEPUTY CHIEF OF LOVE		312. SIGNATURE OF ASST. CHIEF OF LOVE		313. SIGNATURE OF CHIEF OF HATE		314. SIGNATURE OF DEPUTY CHIEF OF HATE		315. SIGNATURE OF ASST. CHIEF OF HATE		316. SIGNATURE OF CHIEF OF GOOD		317. SIGNATURE OF DEPUTY CHIEF OF GOOD		318. SIGNATURE OF ASST. CHIEF OF GOOD		319. SIGNATURE OF CHIEF OF EVIL		320. SIGNATURE OF DEPUTY CHIEF OF EVIL		321. SIGNATURE OF ASST. CHIEF OF EVIL		322. SIGNATURE OF CHIEF OF LIGHT		323. SIGNATURE OF DEPUTY CHIEF OF LIGHT		324. SIGNATURE OF ASST. CHIEF OF LIGHT		325. SIGNATURE OF CHIEF OF DARKNESS		326. SIGNATURE OF DEPUTY CHIEF OF DARKNESS		327. SIGNATURE OF ASST. CHIEF OF DARKNESS		328. SIGNATURE OF CHIEF OF KNOWLEDGE		329. SIGNATURE OF DEPUTY CHIEF OF KNOWLEDGE		330. SIGNATURE OF ASST. CHIEF OF KNOWLEDGE		331. SIGNATURE OF CHIEF OF IGNORANCE		332. SIGNATURE OF DEPUTY CHIEF OF IGNORANCE		333. SIGNATURE OF ASST. CHIEF OF IGNORANCE		334. SIGNATURE OF CHIEF OF WISDOM		335. SIGNATURE OF DEPUTY CHIEF OF WISDOM		336. SIGNATURE OF ASST. CHIEF OF WISDOM		337. SIGNATURE OF CHIEF OF FOOLISHNESS		338. SIGNATURE OF DEPUTY CHIEF OF FOOLISHNESS		339. SIGNATURE OF ASST. CHIEF OF FOOLISHNESS		340. SIGNATURE OF CHIEF OF VIRTUE		341. SIGNATURE OF DEPUTY CHIEF OF VIRTUE		342. SIGNATURE OF ASST. CHIEF OF VIRTUE		343. SIGNATURE OF CHIEF OF VICE		344. SIGNATURE OF DEPUTY CHIEF OF VICE		345. SIGNATURE OF ASST. CHIEF OF VICE		346. SIGNATURE OF CHIEF OF CLEANLINESS		347. SIGNATURE OF DEPUTY CHIEF OF CLEANLINESS		348. SIGNATURE OF ASST. CHIEF OF CLEANLINESS		349. SIGNATURE OF CHIEF OF DIRTYNESS		350. SIGNATURE OF DEPUTY CHIEF OF DIRTYNESS		351. SIGNATURE OF ASST. CHIEF OF DIRTYNESS		352. SIGNATURE OF CHIEF OF ORDER		353. SIGNATURE OF DEPUTY CHIEF OF ORDER		354. SIGNATURE OF ASST. CHIEF OF ORDER		355. SIGNATURE OF CHIEF OF DISORDER		356. SIGNATURE OF DEPUTY CHIEF OF DISORDER		357. SIGNATURE OF ASST. CHIEF OF DISORDER		358. SIGNATURE OF CHIEF OF CALM		359. SIGNATURE OF DEPUTY CHIEF OF CALM		360. SIGNATURE OF ASST. CHIEF OF CALM		361. SIGNATURE OF CHIEF OF CHAOS		362. SIGNATURE OF DEPUTY CHIEF OF CHAOS		363. SIGNATURE OF ASST. CHIEF OF CHAOS		364. SIGNATURE OF CHIEF OF HAPPINESS		365. SIGNATURE OF DEPUTY CHIEF OF HAPPINESS		366. SIGNATURE OF ASST. CHIEF OF HAPPINESS		367. SIGNATURE OF CHIEF OF SADNESS		368. SIGNATURE OF DEPUTY CHIEF OF SADNESS		369. SIGNATURE OF ASST. CHIEF OF SADNESS		370. SIGNATURE OF CHIEF OF JOY		371. SIGNATURE OF DEPUTY CHIEF OF JOY		372. SIGNATURE OF ASST. CHIEF OF JOY		373. SIGNATURE OF CHIEF OF GRIEF		374. SIGNATURE OF DEPUTY CHIEF OF GRIEF		375. SIGNATURE OF ASST. CHIEF OF GRIEF		376. SIGNATURE OF CHIEF OF HOPE		377. SIGNATURE OF DEPUTY CHIEF OF HOPE		378. SIGNATURE OF ASST. CHIEF OF HOPE		379. SIGNATURE OF CHIEF OF DESPAIR		380. SIGNATURE OF DEPUTY CHIEF OF DESPAIR		381. SIGNATURE OF ASST. CHIEF OF DESPAIR		382. SIGNATURE OF CHIEF OF FAITH		383. SIGNATURE OF DEPUTY CHIEF OF FAITH		384. SIGNATURE OF ASST. CHIEF OF FAITH		385. SIGNATURE OF CHIEF OF UNBELIEF		386. SIGNATURE OF DEPUTY CHIEF OF UNBELIEF		387. SIGNATURE OF ASST. CHIEF OF UNBELIEF		388. SIGNATURE OF CHIEF OF TRUTH		389. SIGNATURE OF DEPUTY CHIEF OF TRUTH		390. SIGNATURE OF ASST. CHIEF OF TRUTH		391. SIGNATURE OF CHIEF OF LIES		392. SIGNATURE OF DEPUTY CHIEF OF LIES		393. SIGNATURE OF ASST. CHIEF OF LIES		394. SIGNATURE OF CHIEF OF REALITY		395. SIGNATURE OF DEPUTY CHIEF OF REALITY		396. SIGNATURE OF ASST. CHIEF OF REALITY		397. SIGNATURE OF CHIEF OF IMAGINATION		398. SIGNATURE OF DEPUTY CHIEF OF IMAGINATION		399. SIGNATURE OF ASST. CHIEF OF IMAGINATION		400. SIGNATURE OF CHIEF OF DREAMS		401. SIGNATURE OF DEPUTY CHIEF OF DREAMS		402. SIGNATURE OF ASST. CHIEF OF DREAMS		403. SIGNATURE OF CHIEF OF NIGHTMARES		404. SIGNATURE OF DEPUTY CHIEF OF NIGHTMARES		405. SIGNATURE OF ASST. CHIEF OF NIGHTMARES		406. SIGNATURE OF CHIEF OF WAKENESS		407. SIGNATURE OF DEPUTY CHIEF OF WAKENESS		408. SIGNATURE OF ASST. CHIEF OF WAKENESS		409. SIGNATURE OF CHIEF OF SLEEP		410. SIGNATURE OF DEPUTY CHIEF OF SLEEP		411. SIGNATURE OF ASST. CHIEF OF SLEEP		412. SIGNATURE OF CHIEF OF CONSCIOUSNESS		413. SIGNATURE OF DEPUTY CHIEF OF CONSCIOUSNESS		414. SIGNATURE OF ASST. CHIEF OF CONSCIOUSNESS		415. SIGNATURE OF CHIEF OF UNCONSCIOUSNESS		416. SIGNATURE OF DEPUTY CHIEF OF UNCONSCIOUSNESS		417. SIGNATURE OF ASST. CHIEF OF UNCONSCIOUSNESS		418. SIGNATURE OF CHIEF OF MIND		419. SIGNATURE OF DEPUTY CHIEF OF MIND		420. SIGNATURE OF ASST. CHIEF OF MIND		421. SIGNATURE OF CHIEF OF BODY		422. SIGNATURE OF DEPUTY CHIEF OF BODY		423. SIGNATURE OF ASST. CHIEF OF BODY		424. SIGNATURE OF CHIEF OF SOUL		425. SIGNATURE OF DEPUTY CHIEF OF SOUL		426. SIGNATURE OF ASST. CHIEF OF SOUL		427. SIGNATURE OF CHIEF OF SPIRIT		428. SIGNATURE OF DEPUTY CHIEF OF SPIRIT		429. SIGNATURE OF ASST. CHIEF OF SPIRIT		430. SIGNATURE OF CHIEF OF MATTER		431. SIGNATURE OF DEPUTY CHIEF OF MATTER		432. SIGNATURE OF ASST. CHIEF OF MATTER		433. SIGNATURE OF CHIEF OF ENERGY		434. SIGNATURE OF DEPUTY CHIEF OF ENERGY		435. SIGNATURE OF ASST. CHIEF OF ENERGY		436. SIGNATURE OF CHIEF OF LIFE		437. SIGNATURE OF DEPUTY CHIEF OF LIFE		438. SIGNATURE OF ASST. CHIEF OF LIFE		439. SIGNATURE OF CHIEF OF DEATH		440. SIGNATURE OF DEPUTY CHIEF OF DEATH		441. SIGNATURE OF ASST. CHIEF OF DEATH		442. SIGNATURE OF CHIEF OF REBIRTH		443. SIGNATURE OF DEPUTY CHIEF OF REBIRTH		444. SIGNATURE OF ASST. CHIEF OF REBIRTH		445. SIGNATURE OF CHIEF OF CREATION		446. SIGNATURE OF DEPUTY CHIEF OF CREATION		447. SIGNATURE OF ASST. CHIEF OF CREATION		448. SIGNATURE OF CHIEF OF DESTRUCTION		449. SIGNATURE OF DEPUTY CHIEF OF DESTRUCTION		450. SIGNATURE OF ASST. CHIEF OF DESTRUCTION		451. SIGNATURE OF CHIEF OF PRESERVATION		452. SIGNATURE OF DEPUTY CHIEF OF PRESERVATION		453. SIGNATURE OF ASST. CHIEF OF PRESERVATION		454. SIGNATURE OF CHIEF OF PROTECTION		455. SIGNATURE OF DEPUTY CHIEF OF PROTECTION		456. SIGNATURE OF ASST. CHIEF OF PROTECTION		457. SIGNATURE OF CHIEF OF DEFENSE		458. SIGNATURE OF DEPUTY CHIEF OF DEFENSE		459. SIGNATURE OF ASST. CHIEF OF DEFENSE		460. SIGNATURE OF CHIEF OF OFFENSE		461. SIGNATURE OF DEPUTY CHIEF OF OFFENSE		462. SIGNATURE OF ASST. CHIEF OF OFFENSE		463. SIGNATURE OF CHIEF OF WAR		464. SIGNATURE OF DEPUTY CHIEF OF WAR		465. SIGNATURE OF ASST. CHIEF OF WAR		466. SIGNATURE OF CHIEF OF PEACE		467. SIGNATURE OF DEPUTY CHIEF OF PEACE		468. SIGNATURE OF ASST. CHIEF OF PEACE		469. SIGNATURE OF CHIEF OF LOVE		470. SIGNATURE OF DEPUTY CHIEF OF LOVE		471. SIGNATURE OF ASST. CHIEF OF LOVE		472. SIGNATURE OF CHIEF OF HATE		473. SIGNATURE OF DEPUTY CHIEF OF HATE		474. SIGNATURE OF ASST. CHIEF OF HATE		475. SIGNATURE OF CHIEF OF GOOD		476. SIGNATURE OF DEPUTY CHIEF OF GOOD		477. SIGNATURE OF ASST. CHIEF OF GOOD		478. SIGNATURE OF CHIEF OF EVIL		479. SIGNATURE OF DEPUTY CHIEF OF EVIL		480. SIGNATURE OF ASST. CHIEF OF EVIL		481. SIGNATURE OF CHIEF OF LIGHT		482. SIGNATURE OF DEPUTY CHIEF OF LIGHT		483. SIGNATURE OF ASST. CHIEF OF LIGHT		484. SIGNATURE OF CHIEF OF DARKNESS		485. SIGNATURE OF DEPUTY CHIEF OF DARKNESS		486. SIGNATURE OF ASST. CHIEF OF DARKNESS		487. SIGNATURE OF CHIEF OF KNOWLEDGE		488. SIGNATURE OF DEPUTY CHIEF OF KNOWLEDGE		489. SIGNATURE OF ASST. CHIEF OF KNOWLEDGE		490. SIGNATURE OF CHIEF OF IGNORANCE		491. SIGNATURE OF DEPUTY CHIEF OF IGNORANCE		492. SIGNATURE OF ASST. CHIEF OF IGNORANCE		493. SIGNATURE OF CHIEF OF WISDOM		494. SIGNATURE OF DEPUTY CHIEF OF WISDOM		495. SIGNATURE OF ASST. CHIEF OF WISDOM		496. SIGNATURE OF CHIEF OF FOOLISHNESS		497. SIGNATURE OF DEPUTY CHIEF OF FOOLISHNESS		498. SIGNATURE OF ASST. CHIEF OF FOOLISHNESS		499. SIGNATURE OF CHIEF OF VIRTUE		500. SIGNATURE OF DEPUTY CHIEF OF VIRTUE		501. SIGNATURE OF ASST. CHIEF OF VIRTUE		502. SIGNATURE OF CHIEF OF VICE		503. SIGNATURE OF DEPUTY CHIEF OF VICE		504. SIGNATURE OF ASST. CHIEF OF VICE		505. SIGNATURE OF CHIEF OF CLEANLINESS		506. SIGNATURE OF DEPUTY CHIEF OF CLEANLINESS		507. SIGNATURE OF ASST. CHIEF OF CLEANLINESS		508. SIGNATURE OF CHIEF OF DIRTYNESS		509. SIGNATURE OF DEPUTY CHIEF OF DIRTYNESS		510. SIGNATURE OF ASST. CHIEF OF DIRTYNESS		511. SIGNATURE OF CHIEF OF ORDER		512. SIGNATURE OF DEPUTY CHIEF OF ORDER		513. SIGNATURE OF ASST. CHIEF OF ORDER		514. SIGNATURE OF CHIEF OF DISORDER		515. SIGNATURE OF DEPUTY CHIEF OF DISORDER		516. SIGNATURE OF ASST. CHIEF OF DISORDER		517. SIGNATURE OF CHIEF OF CALM		518. SIGNATURE OF DEPUTY CHIEF OF CALM		519. SIGNATURE OF ASST. CHIEF OF CALM		520. SIGNATURE OF CHIEF OF CHAOS		521. SIGNATURE OF DEPUTY CHIEF OF CHAOS		522. SIGNATURE OF ASST. CHIEF OF CHAOS		523. SIGNATURE OF CHIEF OF HAPPINESS		524. SIGNATURE OF DEPUTY CHIEF OF HAPPINESS		525. SIGNATURE OF ASST. CHIEF OF HAPPINESS		526. SIGNATURE OF CHIEF OF SADNESS		527. SIGNATURE OF DEPUTY CHIEF OF SADNESS		528. SIGNATURE OF ASST. CHIEF OF SADNESS		529. SIGNATURE OF CHIEF OF JOY		530. SIGNATURE OF DEPUTY CHIEF OF JOY		531. SIGNATURE OF ASST. CHIEF OF JOY		532. SIGNATURE OF CHIEF OF GRIEF		533. SIGNATURE OF DEPUTY CHIEF OF GRIEF		534. SIGNATURE OF ASST. CHIEF OF GRIEF	
---------------------	--	--------	--	--------	--	---------	--	---------------	--	-------------------	--	------------------	--	------------------	--	-------------------	--	--------------------	--	---------------------	--	----------------------------	--	----------------------------	--	----------------------------	--	--------------------------	--	-----------------------	--	------------------------	--	------------------------	--	--------------------------	--	---------------------------------	--	----------------------------	--	-------------------------	--	-------------------------	--	----------------------------------	--	---	--	-------------------------------	--	--------------------------	--	----------------------------	--	----------------------------	--	----------------------------------	--	-------------------------------	--	-----------------------------	--	----------------------------	--	--------------------------------------	--	---	--	--	--	------------------------------------	--	---	--	--	--	-----------------------------------	--	--	--	---	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-----------------------------------	--	--	--	---	--	-------------------------------------	--	--	--	---	--	-----------------------------------	--	--	--	---	--	------------------------------------	--	---	--	--	--	--------------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	----------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	------------------------------------	--	---	--	--	--	-------------------------------	--	--------------------------------------	--	-------------------------------------	--	----------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	-------------------------------	--	--------------------------------------	--	-------------------------------------	--	----------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	-----------------------------------	--	--	--	---	--	-----------------------------------	--	--	--	---	--	---------------------------------	--	--	--	---------------------------------------	--	----------------------------------	--	---	--	--	--	------------------------------------	--	---	--	--	--	-------------------------------------	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	---------------------------------------	--	--	--	---	--	------------------------------------	--	---	--	--	--	------------------------------------	--	---	--	--	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	----------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	----------------------------------	--	---	--	--	--	-------------------------------------	--	--	--	---	--	--------------------------------------	--	---	--	--	--	--------------------------------------	--	---	--	--	--	-----------------------------------	--	--	--	---	--	--	--	---	--	--	--	-----------------------------------	--	--	--	---	--	---------------------------------	--	--	--	---------------------------------------	--	--	--	---	--	--	--	--------------------------------------	--	---	--	--	--	----------------------------------	--	---	--	--	--	-------------------------------------	--	--	--	---	--	---------------------------------	--	--	--	---------------------------------------	--	----------------------------------	--	---	--	--	--	--------------------------------------	--	---	--	--	--	------------------------------------	--	---	--	--	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	----------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	------------------------------------	--	---	--	--	--	----------------------------------	--	---	--	--	--	----------------------------------	--	---	--	--	--	-----------------------------------	--	--	--	---	--	-------------------------------------	--	--	--	---	--	----------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	------------------------------------	--	---	--	--	--	--	--	---	--	--	--	-----------------------------------	--	--	--	---	--	---------------------------------------	--	--	--	---	--	-------------------------------------	--	--	--	---	--	----------------------------------	--	---	--	--	--	--	--	---	--	--	--	--	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	-----------------------------------	--	--	--	---	--	-----------------------------------	--	--	--	---	--	-----------------------------------	--	--	--	---	--	---------------------------------	--	--	--	---------------------------------------	--	----------------------------------	--	---	--	--	--	------------------------------------	--	---	--	--	--	-------------------------------------	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	---------------------------------------	--	--	--	---	--	------------------------------------	--	---	--	--	--	------------------------------------	--	---	--	--	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	----------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	----------------------------------	--	---	--	--	--	-------------------------------------	--	--	--	---	--	--------------------------------------	--	---	--	--	--	--------------------------------------	--	---	--	--	--	-----------------------------------	--	--	--	---	--	--	--	---	--	--	--	-----------------------------------	--	--	--	---	--	---------------------------------	--	--	--	---------------------------------------	--	--	--	---	--	--	--	--------------------------------------	--	---	--	--	--	----------------------------------	--	---	--	--	--	-------------------------------------	--	--	--	---	--	---------------------------------	--	--	--	---------------------------------------	--	----------------------------------	--	---	--	--	--	--------------------------------------	--	---	--	--	--	------------------------------------	--	---	--	--	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	----------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	------------------------------------	--	---	--	--	--	----------------------------------	--	---	--	--	--	-------------------------------------	--	--	--	---	--	----------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	------------------------------------	--	---	--	--	--	--	--	---	--	--	--	-----------------------------------	--	--	--	---	--	---------------------------------------	--	--	--	---	--	-------------------------------------	--	--	--	---	--	----------------------------------	--	---	--	--	--	--	--	---	--	--	--	--	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	-----------------------------------	--	--	--	---	--	-----------------------------------	--	--	--	---	--	-----------------------------------	--	--	--	---	--	---------------------------------	--	--	--	---------------------------------------	--	----------------------------------	--	---	--	--	--	------------------------------------	--	---	--	--	--	-------------------------------------	--	--	--	---	--	--	--	---	--	--	--	---	--	--	--	---	--	---------------------------------------	--	--	--	---	--	------------------------------------	--	---	--	--	--	------------------------------------	--	---	--	--	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	----------------------------------	--	---	--	--	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	---------------------------------	--	--	--	---------------------------------------	--	----------------------------------	--	---	--	--	--	-------------------------------------	--	--	--	---	--	--------------------------------------	--	---	--	--	--	--------------------------------------	--	---	--	--	--	-----------------------------------	--	--	--	---	--	--	--	---	--	--	--	-----------------------------------	--	--	--	---	--	---------------------------------	--	--	--	---------------------------------------	--	--	--	---	--	--	--	--------------------------------------	--	---	--	--	--	----------------------------------	--	---	--	--	--	-------------------------------------	--	--	--	---	--	---------------------------------	--	--	--	---------------------------------------	--	----------------------------------	--	---	--	--	--	--------------------------------------	--	---	--	--	--	------------------------------------	--	---	--	--	--	--------------------------------	--	---------------------------------------	--	--------------------------------------	--	----------------------------------	--	---	--	--	--

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2756 CERTIFICATE OF DEATH

02739

Reg. Dist. No. 75

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Manchester #1</u>				STREET ADDRESS (If rural, give location) <u>Manchester #1</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles H Tracy</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>7/5/1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John W. Tracy</u>				14. MOTHER'S MAIDEN NAME <u>Margaret C. Tracy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Jesse Tracy, Manchester, Md #</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>						5 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma Prostate Gland</u>						2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>March 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>56</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. H. F. Oand</u>				M.D. <u>Manchester, Md.</u>		DATE SIGNED <u>3/4/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Harzard Cemetery</u>		LOCATION (City, town, or county) (State) <u>Carroll Co</u>	
24. REC'D BY REGISTRAR <u>Mar. 7/56</u>		REGISTRAR'S SIGNATURE <u>Mrs. W. P. L. Deener</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ardenck Becker</u>		ADDRESS <u>Harzard</u>	

STATE CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John M. Gandy</i>		2. SEX <i>Male</i>	
3. AGE <i>41</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>March 12, 1956</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>	
9. SIGNATURE OF PHYSICIAN <i>John M. Gandy</i>		10. SIGNATURE OF REGISTRAR <i>John M. Gandy</i>	
11. SIGNATURE OF WITNESS <i>John M. Gandy</i>		12. SIGNATURE OF WITNESS <i>John M. Gandy</i>	

RECEIVED
MAR 12 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2757 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02740

Reg. Dist. No. *TH*

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 2yr.8mo.20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		15-26-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 1107 Agnew Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOHN Last TROTTER				4. DATE OF DEATH Month March Day 22 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/22/88	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Joseph Trotter				14. MOTHER'S MAIDEN NAME Mary Jane O'Doherty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Springfield State Hospital Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO (b) Aortic stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 904.7 DUE TO (c) Rheumatic heart disease INTERVAL BETWEEN ONSET AND DEATH 3 days Yrs. Yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subdural Hemorrhage C.B.S. assoc. with dist. of metab. growth or nu- trition, senile brain disease, psychosis.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell and struck his head.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3/14/56 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James T. Marsh</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James T. Marsh, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURNAL CREMATION, REMOVAL (Specify) Burial-Transit				22b. DATE THEREOF 3-23-56		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.	
				22d. LOCATION (City, town, or county) (State) Philadelphia, Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert H. Humphrey</i>				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 3-27-56	
				24b. REGISTRAR'S SIGNATURE <i>C. Harry W...</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 2 1936

BUREAU V. S.

MAYNARD STATE DEPARTMENT OF HEALTH-BALDWIN 10	
2575 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
Name of Deceased: <u>WILLIAM J. MAYNARD</u>	
Age: <u>40</u> Sex: <u>Male</u>	
Date of Death: <u>March 2, 1936</u>	
Place of Death: <u>Home</u>	
Cause of Death: <u>Heart Disease</u>	
Signature of Examiner: <u>[Signature]</u>	
Official Seal: <u>[Seal]</u>	
Remarks: <u>[Blank]</u>	

2758

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wash. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown. 21-03-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Springfield State Hosp.				d. STREET ADDRESS 543 N. Mulberry St.			
3. NAME OF DECEASED (Type or print) Dorothy Swope Trovinger				4. DATE OF DEATH Month 3- Day 2- Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-69	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --66-----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Simon Swope				14. MOTHER'S MAIDEN NAME Sara ?.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unk - -		16. SOCIAL SECURITY NO. unk -		17. INFORMANT Bessie E. Itnyre, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Chronic Myocarditis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 Days. 10 Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-3 , 19 56 , to 3-2- , 19 56 , that I last saw the deceased alive on 3-2- , 19 56 , and that death occurred at 2-12A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED 3-2-56							
ACTUAL SIGNATURE M. Mastin M.D.				PHYSICIAN'S NAME (Type) M.N. Mastin M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-5-56		22c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown		24a. REC'D BY REGISTRAR DATE 3-2-56	
				24b. REGISTRAR'S SIGNATURE C. Harry Eiden			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES J. JONES		Male		45		1910		New York City		Teacher	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
1956		10:30 AM		Home		Heart Disease		Natural		J. J. Jones	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CLERK		16. SIGNATURE OF DEPUTY CLERK		17. SIGNATURE OF ASSISTANT CLERK		18. SIGNATURE OF CHIEF CLERK	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	

BUREAU V. 3

MAR 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

02742

2411 N. Charles Street, Baltimore

2721

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Westminster		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS County Home		STREET ADDRESS (If rural, give location) Old Westminster Road	
3. NAME OF DECEASED (Type or Print)	(First) William (Middle) G. (Last) Uhler	4. DATE OF DEATH (Month) March (Day) 19 (Year) 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Feb. 24, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 89 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME Washington Uhler		14. MOTHER'S MAIDEN NAME Mary Flater	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY No. None	
		17. INFORMANT AND ADDRESS Roger Peeling, Finksburg, Md.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause 450.0 (a) Cardiac Dehydration			3 day
Antecedent cause(s) (b) Arterio Sclerosis			1 ?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) 220	PLACE (Home, farm, factory, street, OF office bldg., etc.) X	(CITY OR TOWN) X	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY X	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **7-6**, 19**55**, to **3-19**, 19**56**, that I last saw the deceased alive on **3-15**, 19**56**, and that death occurred at **12:15 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE Mar. 22, 1956	NAME OF CEMETERY OR CREMATORY Sandymount	LOCATION (City, town, or county) Carroll County (State)
DATE REC'D BY LOCAL REG. 3-20-56	REGISTRAR'S SIGNATURE Mary D. Eline	24. FUNERAL DIRECTOR J.F. Eline & Sons, Reisterstown, Md. ADDRESS	

Harriet Miller

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02743
Item 3: Film G195 4/11/56 dmr.										74
2759										CERTIFICATE OF DEATH
Reg. Dist. No.										74
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville					c. LENGTH OF STAY IN 1b 2yrs.2moths18days Baltimore					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3401-4 ✓
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					d. STREET ADDRESS 3121 Orlando Ave. Baltimore 14					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gustave Middle MAX Last James Wagner					4. DATE OF DEATH Month March Day 17 Year 1956					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17-79		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Max Wagner					14. MOTHER'S MAIDEN NAME Annie Fisher					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT From hospital records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis from cancer of the prostate - months. 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome asso. with dist. of growth, metab., or nutrition, with senile brain disease with psychotic reaction										INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-30- , 1953 , to 3-17- , 1956 , that I last saw the deceased alive on 3-17- , 1956 , and that death occurred at 3.25 PM , from the causes and on the date stated above.										
ACTUAL SIGNATURE Agustin del Campo M.D.					ADDRESS (Street, city or town, state) Springfield State Hospital					DATE SIGNED 3-17-56
PHYSICIAN'S NAME (Type) Agustin del Campo										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 21/56		22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery			22d. LOCATION (City, town, or county) (State) Martinsburg W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witte					ADDRESS 4101 Edmondson Ave		24a. REC'D BY REGISTRAR March 20, 1956		24b. REGISTRAR'S SIGNATURE C. Harry Jones	

RECEIVED

2760

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 6/6/55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 5203 Greenhill Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ludwig Middle - Last WEIGL				4. DATE OF DEATH Month March Day 1st Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1901	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months - Days - Hours - Min. -	IF UNDER 74 HRS. Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinetmaker		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Australia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Weigl				14. MOTHER'S MAIDEN NAME Julia - ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-09-0245		17. INFORMANT Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute meningitis, type undetermined 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Old subdural hemorrhage, left side DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH 1 day more than 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with disturbance of metabolism, growth or nutrition, presenile brain disease, with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- p. m. --- 19 ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from Sept. 26th, 1955 , to February 29, 1956 , that I last saw the deceased alive on February 29, 1956 , and that death occurred at 5:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Sykesville, Maryland			
DATE SIGNED 3/1/56							
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 5, 1956		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14				24a. REC'D BY REGISTRAR DATE 3-1-56		24b. REGISTRAR'S SIGNATURE C. J. Hargrave	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2761

CERTIFICATE OF DEATH

03900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION TOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION TOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>MARGIE</u> First <u>G. WERTENBAKER</u> Middle <u>1</u> Last		4. DATE OF DEATH <u>MARCH 15</u> Month <u>1956</u> Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE WERTENBAKER</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE CARTER DAFNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. ALMA STONER</u>		Address <u>UNION TOWN, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 1, 1956</u> , to <u>Mar 15, 1956</u> , that I last saw the deceased alive on <u>Mar 15, 1956</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. N. Regg</u>		ADDRESS (Street, city or town, state) <u>Union Bridge, Md.</u> DATE SIGNED <u>3-16-56</u>	
PHYSICIAN'S NAME (Type) <u>T. H. Legg, M.D.</u>		<u>Union Bridge, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>UNION TOWN, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD. HARTZLER & SONS, NEW WINDSOR, MD.</u>		24a. REC'D BY REGISTRAR <u>3/18/56</u> 24b. REGISTRAR'S SIGNATURE <u>Margaret K. Engle</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

[illegible]

BUREAU V. B.

APR 10 1956

RECEIVED

2752 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>		LENGTH OF STAY (In this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Smithville, Taylors Island</u>		<u>09X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 87 Smithville</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Wilson Hawthorne Wheatley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 1 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-22-1926</u>	9. AGE last birthday <u>29</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Taylors Island, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Malachi Wheatley</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W. W. II 215-20-0466</u>		17. INFORMANT & ADDRESS <u>Wilson H. Wheatley - Taylors Island, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Far advanced pulmonary Tbc with cavitation</u>							
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-29-</u> <u>19 56</u> , to <u>3-1-</u> <u>19 56</u> , that I last saw the deceased alive on <u>3-1-</u> <u>19 56</u> , and that death occurred at <u>10 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>T. F. Wheatley</u>		M.D. <u>Henryton State Hospital</u>		ADDRESS (Street, city, town, state) <u>Smithville, Dorchester Co. Md.</u>		DATE SIGNED <u>3-1-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal-Burial</u>		DATE THEREOF <u>3/5/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Smithville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dorchester Co. Md.</u>	
24. REC'D BY REGISTRAR DATE <u>3-1-56</u>		REGISTRAR'S SIGNATURE <u>Albert R. Swankhaus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. St. Clair Jr.</u>		ADDRESS <u>Cambridge Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02746

2763

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hicksburg</u>	c. LENGTH OF STAY IN 1b <u>8 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hicksburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MAGGIE - MAY - WILLEY</u> First Middle Last		4. DATE OF DEATH <u>March 19</u> Month Day Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6 - 1879</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Samuel Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Frances Hunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>420</u>	17. INFORMANT <u>John E. Willey, Hicksburg Md</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 51, 1951</u> to <u>March 19, 1956</u> , that I last saw the deceased alive on <u>March 18, 1956</u> , and that death occurred at <u>9</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u> DATE SIGNED <u>3/19/56</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		<u>3/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 21-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East Newmarket Mth</u>	22d. LOCATION (City, town, or county) (State) <u>Bonchester Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Elvine & Sons</u>		ADDRESS <u>Reisterstown Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 3-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02747

2764 CERTIFICATE OF DEATH

Reg. Dist. No. 75

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL CO.</u>		STATE <u>M.D.</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINISTER</u>		TOWN <u>WESTMINISTER</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>ROUTE 4 ARNOLD</u>		TOWN <u>WESTMINISTER</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 4 ARNOLD ROAD</u>				STREET ADDRESS <u>ROUTE 4 ARNOLD</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>VERONICA SHIRLEY WOJICK</u>				<u>May 6 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>AUGUST 26-1943</u>	<u>12</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO. M.D.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HENRY WOJICK</u>				14. MOTHER'S MAIDEN NAME <u>VERONICA KROLICHA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Henry Wojick Route 4 Arnold Rd Westminster Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
754.4 IMMEDIATE CAUSE (A) <u>VIRAL RESPIRATORY DISEASE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>CONGENITAL HEART DISEASE</u>				<u>12 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1956</u>, to <u>MAY 6</u>, 19<u>56</u>, that I last saw the deceased alive on <u>3/5</u>, 19<u>56</u>, and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James J. Marsh</u> M.D.				DATE SIGNED <u>3/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR			
DATE THEREOF <u>3/9/56</u>		NAME OF CEMETERY OR CREMATORY <u>SACRED HEART MARY</u>		LOCATION (City, town, or county) <u>BALTO. CO. M.D.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Fialkowski</u>		ADDRESS <u>2007 Eastern Ave</u>	
DATE <u>Mar 7, 1956</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02748

2765

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LOCUST ST.</u>		d. STREET ADDRESS <u>LOCUST ST</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM THORNTON YINGLING</u>		4. DATE OF DEATH Month <u>16</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/1899</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RR SHOPS</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>WILLIAM YINGLING</u>		14. MOTHER'S MAIDEN NAME <u>MOBIE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES WW II</u>		16. SOCIAL SECURITY NO. <u>213-16-0478</u>	
17. INFORMANT <u>MRS MARY YINGLING</u>		Address <u>UNION BRIDGE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis - Chronic Collyer</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis - Nephritis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 24</u> , 19 <u>56</u> , to <u>Mar 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 24</u> , 19 <u>56</u> , and that death occurred at <u>4:10 A.M.</u> , from the causes and on the date stated above. <u>Mar. 15</u>			
ACTUAL SIGNATURE <u>T. H. Legg</u> M.D.		ADDRESS (Street, city or town, state) <u>Union Bridge MD</u>	
DATE SIGNED <u>3-16-56</u>			
PHYSICIAN'S NAME (Type) <u>T. H. LEGG MD</u>		ADDRESS <u>UNION BRIDGE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH OF GOD CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>UNIONTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD HARTZLER & SONS</u>		ADDRESS <u>UNION BRIDGE MD</u>	
24a. REC'D BY REGISTRAR <u>3/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Legg</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1911		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JUN 15 1935		BALTIMORE, MD.		JANE HARRIS		MAR 20 1956		BALTIMORE, MD.	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		NAME OF EMPLOYER		CAUSE OF DEATH		MANNER OF DEATH	
LABORER		JAN 15 1911		BALTIMORE, MD.		JAMES H. HARRIS		HEART DISEASE		NATURAL	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION		NAME OF SCHOOL		SIGNS AND SYMPTOMS		TREATMENT	
HIGH SCHOOL		JAN 15 1911		BALTIMORE, MD.		JAMES H. HARRIS		PAIN IN CHEST		NO	
RELIGION		DATE OF RELIGION		PLACE OF RELIGION		NAME OF CHURCH		PREVIOUS ILLNESS		DATE OF ONSET	
METHODIST		JAN 15 1911		BALTIMORE, MD.		JAMES H. HARRIS		NO		JAN 15 1911	
DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		NAME OF HOSPITAL		DATE OF BURIAL		PLACE OF BURIAL	
MAR 20 1956		BALTIMORE, MD.		JAMES H. HARRIS		JAMES H. HARRIS		MAR 20 1956		BALTIMORE, MD.	

BUREAU V. S.

MAR 20 1956

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.